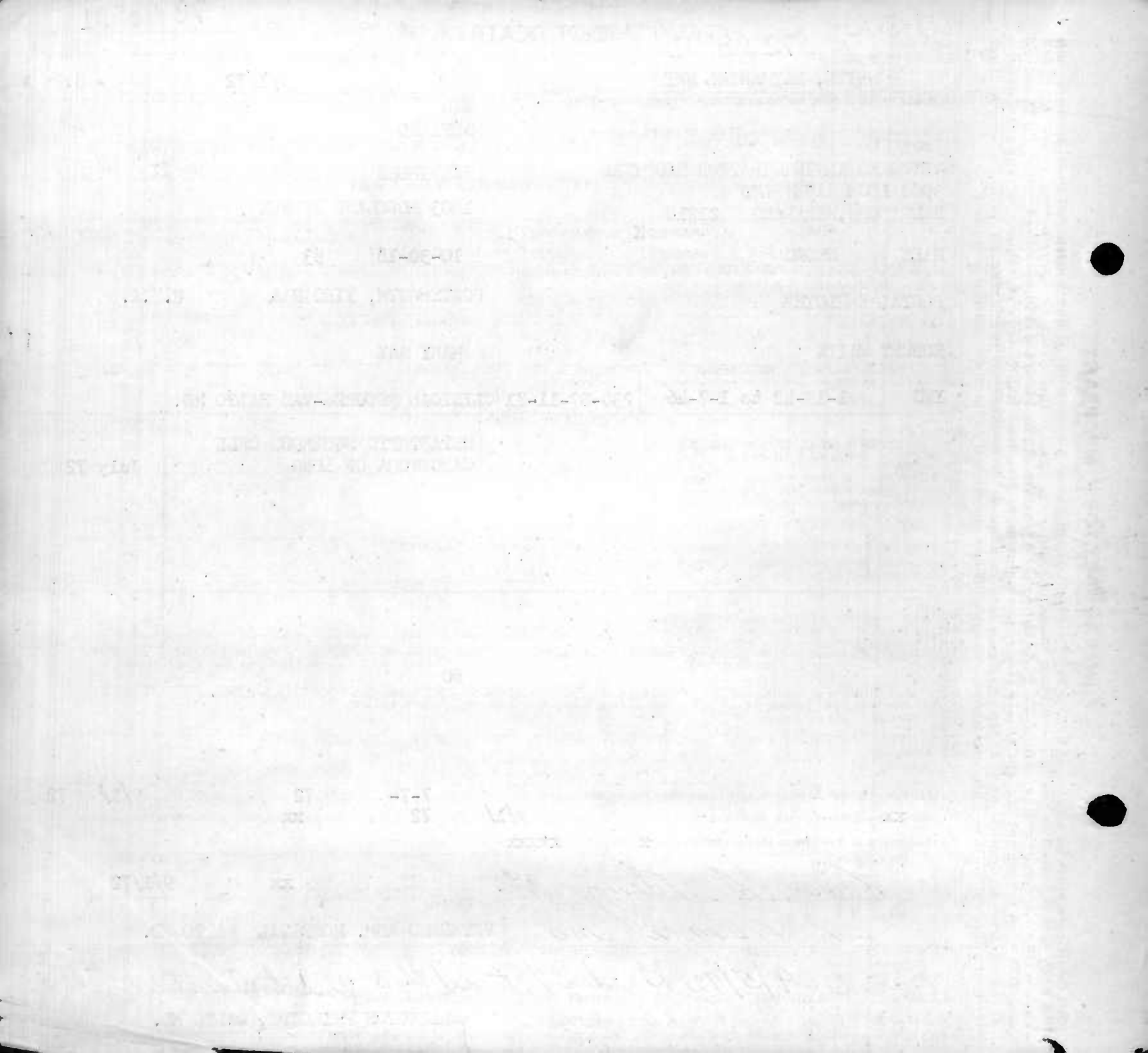


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08501</b>	
W-300 BIRTH NO. <b>72 08501</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WHITE, NATHANIEL NMI</b>			2. DATE AND HOUR OF DEATH <b>9/1/72 8:25 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1503</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>MALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>10-30-18</b> 9. AGE (In years last birthday) <b>53</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTAL EMPLOYEE</b>			11. BIRTHPLACE (State or foreign country) <b>PORTSMOUTH, VIRGINIA</b>		
13. FATHER'S NAME <b>ROBERT WHITE</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1-19-42 to 1-7-46</b>			16. SOCIAL SECURITY NO. <b>230-07-11-81</b>		
17. INFORMANT <b>CLINICAL RECORDS-VAH BALTO MD.</b>			ADDRESS		
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH <b>METASTATIC SQUAMOUS CELL CARCINOMA OF LUNG</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <b>1-19-42</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that <b>I</b> (this hospital) attended the deceased from <b>7-7-72</b> to <b>9/1/1972</b> , that <b>we</b> last saw the deceased alive on <b>9/1/1972</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>we</b> (We) (did) <b>not</b> view the body after death.					
23A. SIGNATURE <i>L. A. Fleming</i>			23B. DATE SIGNED <b>9/1/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>L. A. FLEMING MD</b>			23D. ADDRESS <b>VETERANS ADM. HOSPITAL BALTO MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/5/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Garden of Eternal Hope Westminster MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <i>L. A. Fleming</i>		25C. FUNERAL DIRECTOR <b>ARLINGTON PHILLIPS, BALTO MD.</b>	

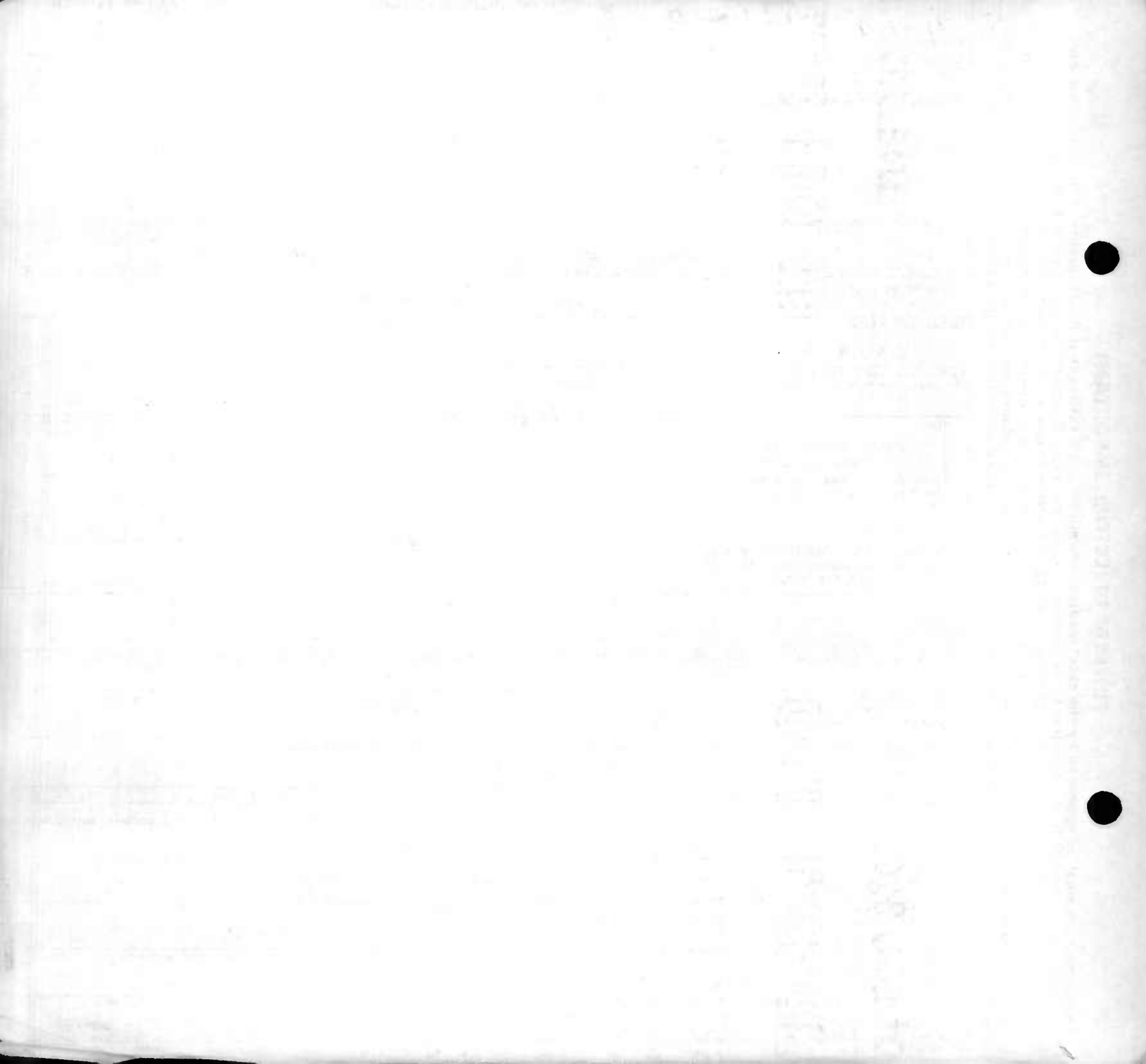




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 08502</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 08502</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Jacqueline A. Miles				9/4 8.25 pm.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44				A. STATE Md			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1537 Lochwood Rd.				2759			
5. SEX F		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-22-33	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		9. AGE (In years last birthday) 39		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME David Frost				12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-30-6344		17. INFORMANT MRS SARAH FROST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastasis (B) <u>Renal carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH March 1972 September 1972	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from 6/23/72 19 to 9/4/72 19 that (I) (we) last saw the deceased alive on 9/4/72 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE <i>Teruel de Campo</i>				23B. DATE SIGNED 9/4/72		23C. PHYSICIAN'S NAME (Type) TERUEL DE CAMPO	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-8-72		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR <i>Lidney</i>		25C. FUNERAL DIRECTOR Wm C MARCH		ADDRESS 928 E. NORTH AVE	



N-550

72 08503

STATE OF MARYLAND-DEMD  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08503

BIRTH NO.

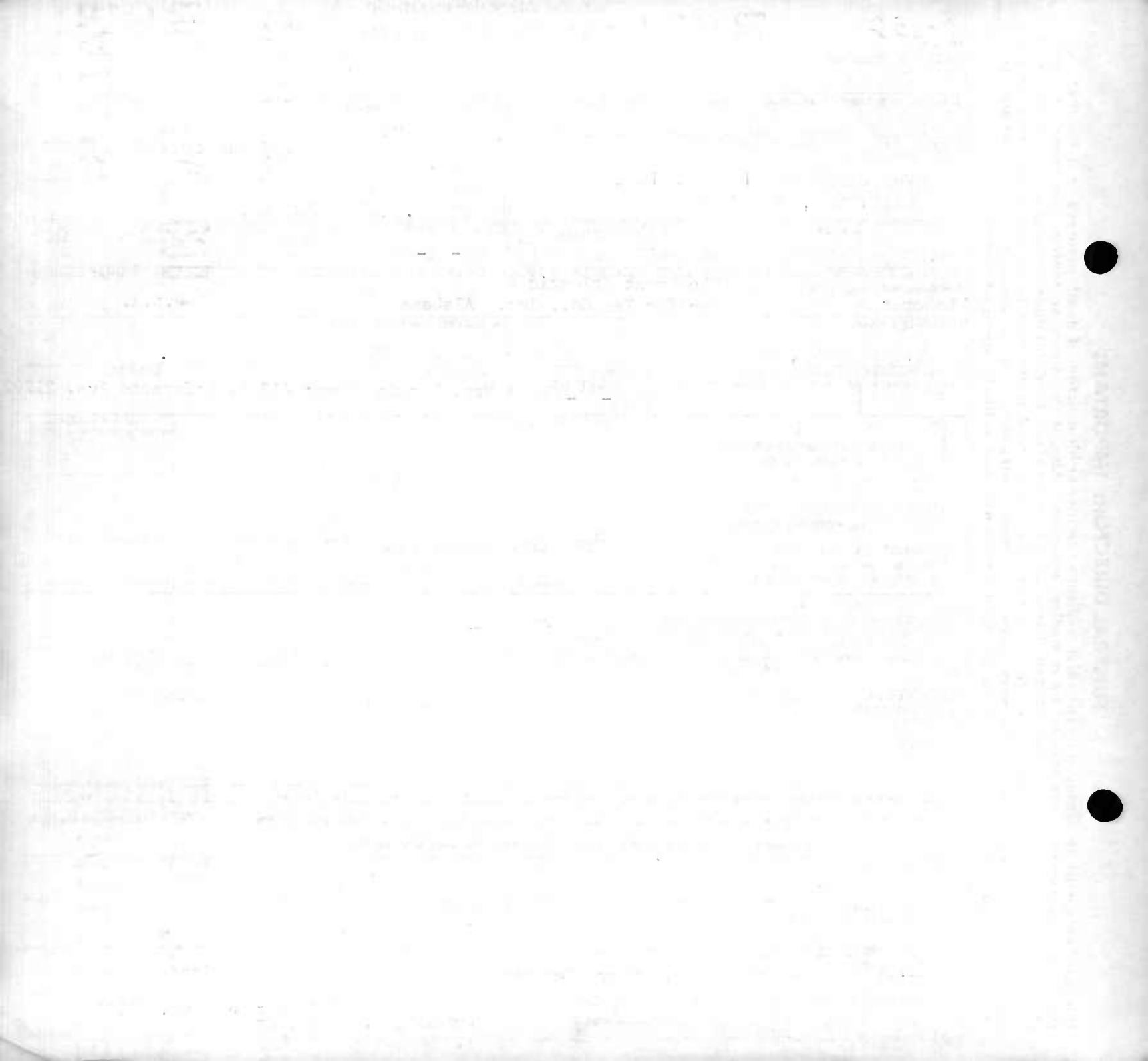
1. NAME OF DECEASED (Type or Print) <b>ROBERT NEWMAN</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>9</b> Day <b>3</b> Year <b>1972</b> Hour <b>11</b> p. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>				3. DATE PRONOUNCED DEAD Month <b>9</b> Day <b>3</b> Year <b>1972</b> Hour <b>11</b> p. M.			
6. SEX <b>male</b>				7. RACE <b>negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Sept 26, 51</b>				10. AGE (In years last birthday) <b>20</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Norman R. Newman</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Library</b>				15. MOTHER'S MAIDEN NAME <b>Estella Woolford</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				17. SOCIAL SECURITY NO. <b>212-56-8470</b>			
18. INFORMANT <b>Mrs. June Newman same</b>				19. ADDRESS <b>Mr. Norman Newman 4107 Glenhunt Rd. 21229</b>			
20. CAUSE OF DEATH <b>Multiple injuries</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>no</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Nicodemus Rd.</b>				22D. TIME OF INJURY (APPROX.) <b>9-3-72 6:00 p.m.</b>			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>Passenger in auto-fixed obj. collision.</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Marvin S. Platt</b> EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>9-4-72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-7-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Adrian Whorton</b>		25C. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr.</b>			

21-10-1955

**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				72 08504		REG. NO. 72 08504	
B-652 BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <b>SILAS BURNS</b>				2. DATE AND HOUR OF DEATH <b>9-4-72 1900 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1205</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>413 E. LAFAYETTE AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-22-82</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>The Great Atlantic &amp; Pacific Tea Co., Inc.</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SILAS BURNS, SR</b>				14. MOTHER'S MAIDEN NAME <b>LEAH PARKER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>424-22-45084</b>		17. INFORMANT <b>Mrs. Bernice Burns 413 E. Lafayette Ave. 21202</b>			
18. <b>412.4</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>LEFT CORTICAL STROKE</b> <b>ASCUD</b> <b>None</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 22</b> 19 <b>72</b> to <b>Sept 4</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Sept 4</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. Kent Osborne M.D.</b>				23B. DATE SIGNED <b>9-4-72</b>		23C. PHYSICIAN'S NAME (Type) <b>C. KENT OSBORNE M.D.</b>	
23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>9-9-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Richard H. Jones</b>		25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 21213 Marshall W. Jones, Jr.</b>			

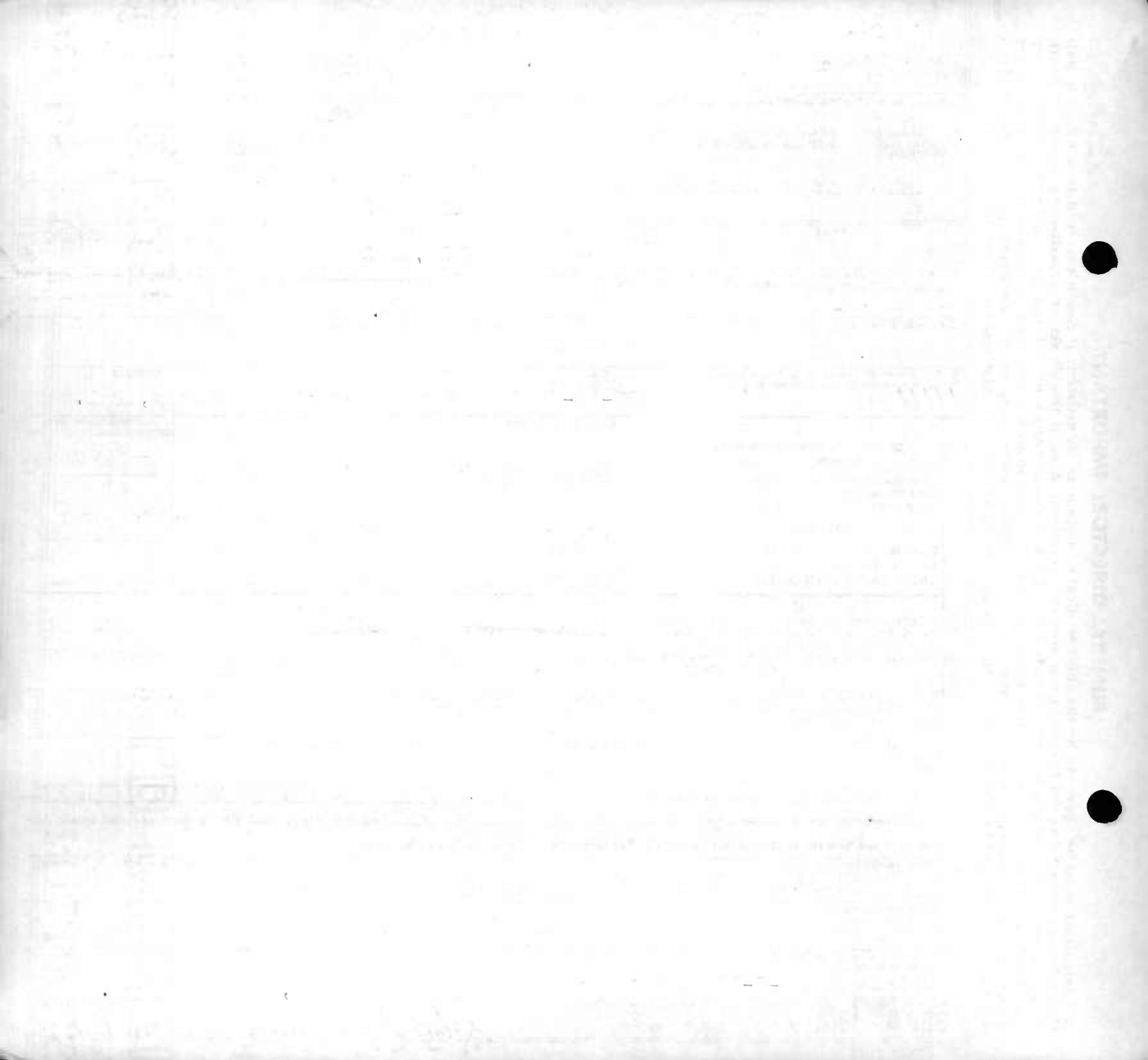




# FUNERAL DIRECTOR: IMPORTANT

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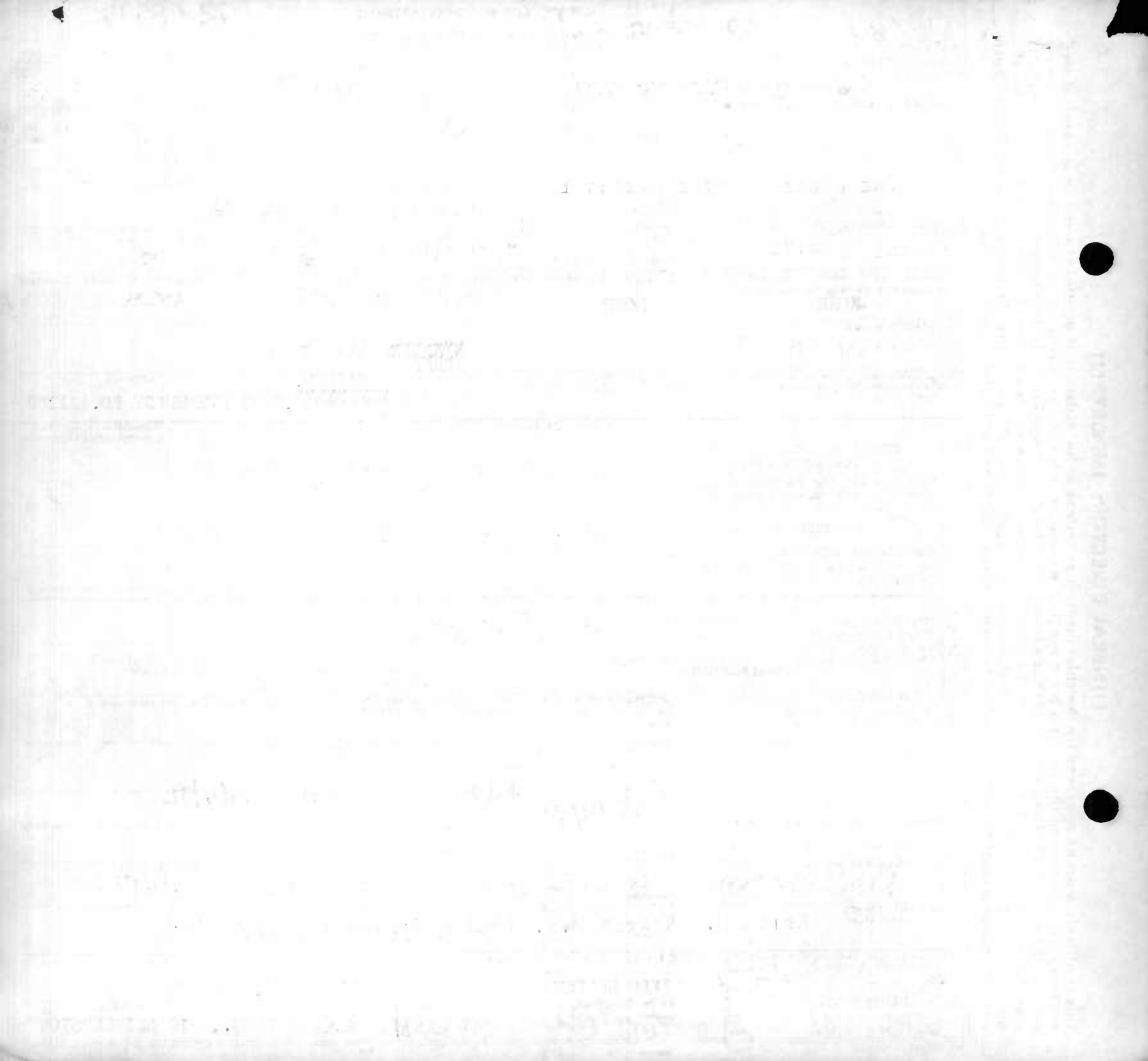
BALTIMORE CITY HEALTH DEPARTMENT				72 08505		12 08505	
BIRTH NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
M-232				MCDUGALL, ELSIE E.		8/30/72 12:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		STATE OF MARYLAND - DHEM	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
THE JOHNS HOPKINS HOSPITAL				DELAWARE KENT		CITY OR TOWN	
				HARTLEY		D. INSIDE CITY LIMITS?	
				E. STREET AND NUMBER		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				RD. 1 BOX 30			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		NOV 18, 1911	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
60		House Wife		Del.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
FRANK GEORGE				ELLA BRANBLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
17/11/11				222-12-3435		Robert McDougall	
						Hartly, Del.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Husband		5 MINUTES	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		CARDIO RESPIRATORY ARREST	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) MYOCARDIAL INFARCTION, CARDIOGENIC SHOCK		36 hrs	
				(C) Lymphosarcoma		2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Diabetes Mellitus		2 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/10/72 1972 to 8/30 1972 that (I) (we) last saw the deceased alive on 8/30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John B. Welch M.D., Ph.D.				8/30/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN B. WELCH M.D., Ph.D.				JOHN HOPKINS HOSP. BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-3-72		Odd Fellows		Camden, Del.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 6 1972		[Signature]		Robert J. Baranco		Serena Park, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

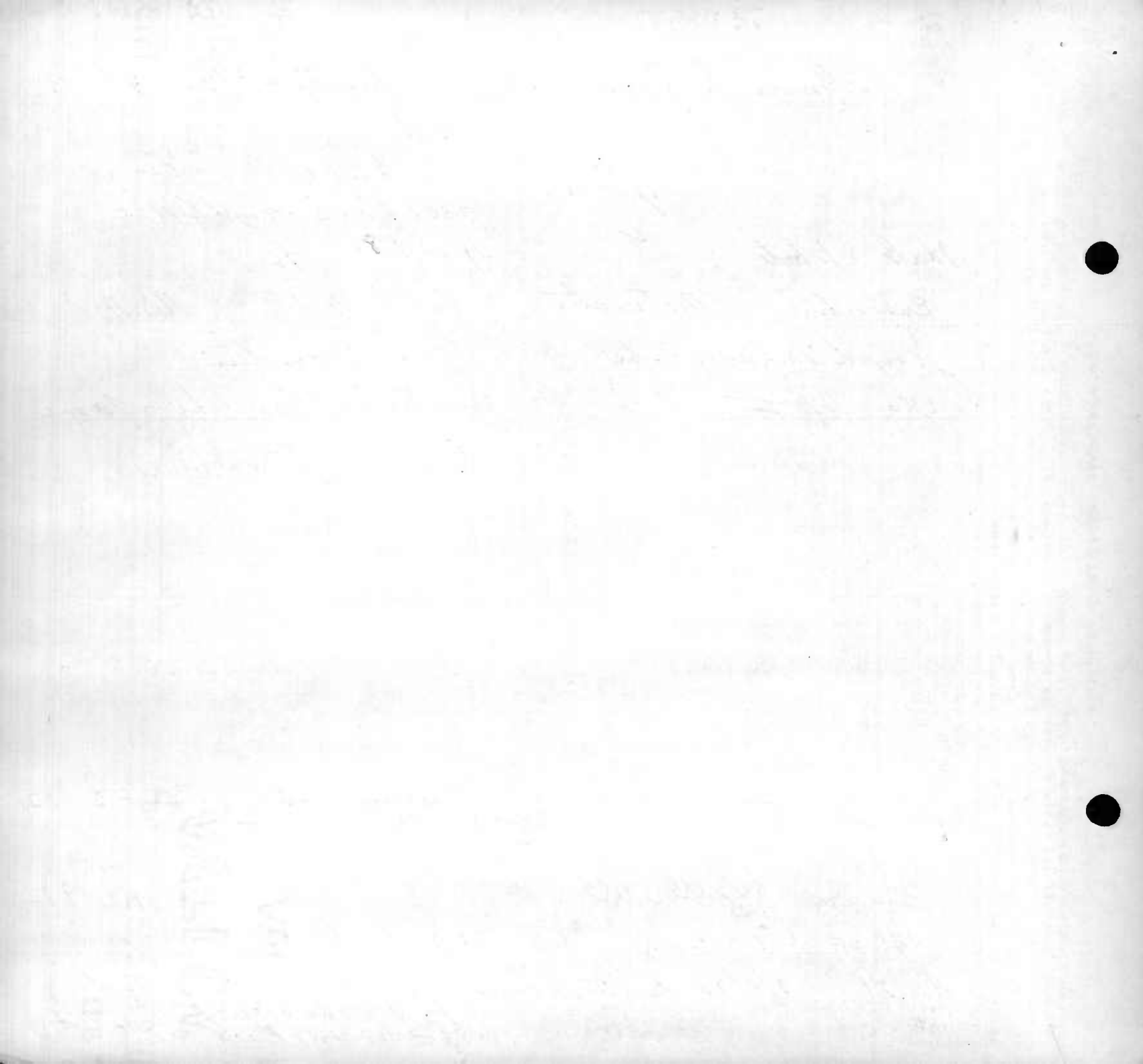
BALTIMORE CITY HEALTH DEPARTMENT				72 08506 4
C-260 72-12888 08506				REG. NO.
BIRTH NO.				STATE OF MARYLAND-DEATH
1. NAME OF DECEASED (Type or Print) <b>Baby girl CASSER</b>		2. DATE AND HOUR OF DEATH <b>9/4/72 2 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2755</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <b>5602 Everhurst Rd.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/72</b>	9. AGE (In years lost birthday) <b>2</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Jerry Casser</b>		
14. MOTHER'S MAIDEN NAME <b>RENA Herzog</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes or Unknown) (If yes, give war or dates of service) <b>(X) Unknown</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>CASSER</b> <b>Jerry Casser</b> , 5602 EVERHURST RD. #21209		
18. <b>746.6 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>renal failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>9/4/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/3/72</b> 19 <b>72</b> to <b>9/4/72</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/4/72</b> 19 <b>72</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Neil H. Senzer</b>		23B. DATE SIGNED <b>9/4/72</b>		23C. PHYSICIAN'S NAME (Type) <b>NEIL H. SENZER M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>9/4/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MIKRO KODESH</b>
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		
25B. NAME OF REGISTRAR <b>John H. Hinton</b>		25C. FUNERAL DIRECTOR <b>SOL BAYLOR &amp; BROS., 6010 REISTERSTOWN RD.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08507	72 08507
CERTIFICATE OF DEATH				REG. NO.	STATE OF MARYLAND-DEMH
BIRTH NO. <b>2-520</b>		1. NAME OF DECEASED (Type or Print) <b>Calman J. Zamoiski</b>		2. DATE AND HOUR OF DEATH <b>Sun Sept 3/72 9<sup>30</sup> P.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>2730</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 7301 Park Heights Ave Apt 402</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Distributor</b>		8. DATE OF BIRTH <b>Apr 2, 1896</b>	
13. FATHER'S NAME <b>Joseph M. Zamoiski</b>		14. MOTHER'S MARDEN NAME <b>Tena Bernstein</b>		9. AGE (In years last birthday) <b>76</b>	
11A. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Gertrude Zamoiski - Same</b>	
18. <b>4-10-9 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Occlusion</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 1955</b> to <b>Sept 3 1972</b> . that (I) ( <del>we</del> ) last saw the deceased alive on <b>Sept 3 1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Jerome J. Coller MD</b>				23B. DATE SIGNED <b>Sept 4, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEROME J. COLLER MD</b>		23D. ADDRESS <b>2217 South Rd.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/5/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto Hebrew Cong. Borocton, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. H. H.</b>		25C. FUNERAL DIRECTOR <b>6010 Reisterstown Rd.</b>	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08508	
R-1/2 72 08508				CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND-DEPT.			
1. NAME OF DECEASED (Type or Print) <i>Nora Rabovsky</i>		2. DATE AND HOUR OF DEATH <i>Sept 13/72 9 15 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2730</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>3107 Bancroft Rd. apt A.</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		8. DATE OF BIRTH <i>May 14, 1889</i>	
13. FATHER'S NAME <i>NACHUM DVORKIN</i>		14. MOTHER'S MAIDEN NAME <i>PESHA ?</i>		9. AGE in years (last birthday) <i>83</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <i>Russian</i>	
18. <i>410.0 I</i>		CAUSE OF DEATH		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
ANTECEDENT CAUSES		(B) <i>H A C U D</i>		<i>12 years</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January 1958</i> to <i>September 3 1972</i> , that (I) (we) last saw the deceased alive on <i>September 3 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Cecil Rudner MD</i>				23B. DATE SIGNED <i>9/3/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>CECIL RUDNER</i>				23D. ADDRESS <i>6821 Reisterstown Rd.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Sept 1/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Sharon Zion</i>	
24D. LOCATION (City, town, or county) (State) <i>Rosebud Md.</i>		24E. FUNERAL DIRECTOR <i>6010 Reisterstown Rd.</i>		24F. ADDRESS <i>6010 Reisterstown Rd.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 6 1972</i>		25B. NAME OF REGISTRAR <i>David H. ...</i>		25C. FUNERAL DIRECTOR <i>6010 Reisterstown Rd.</i>	

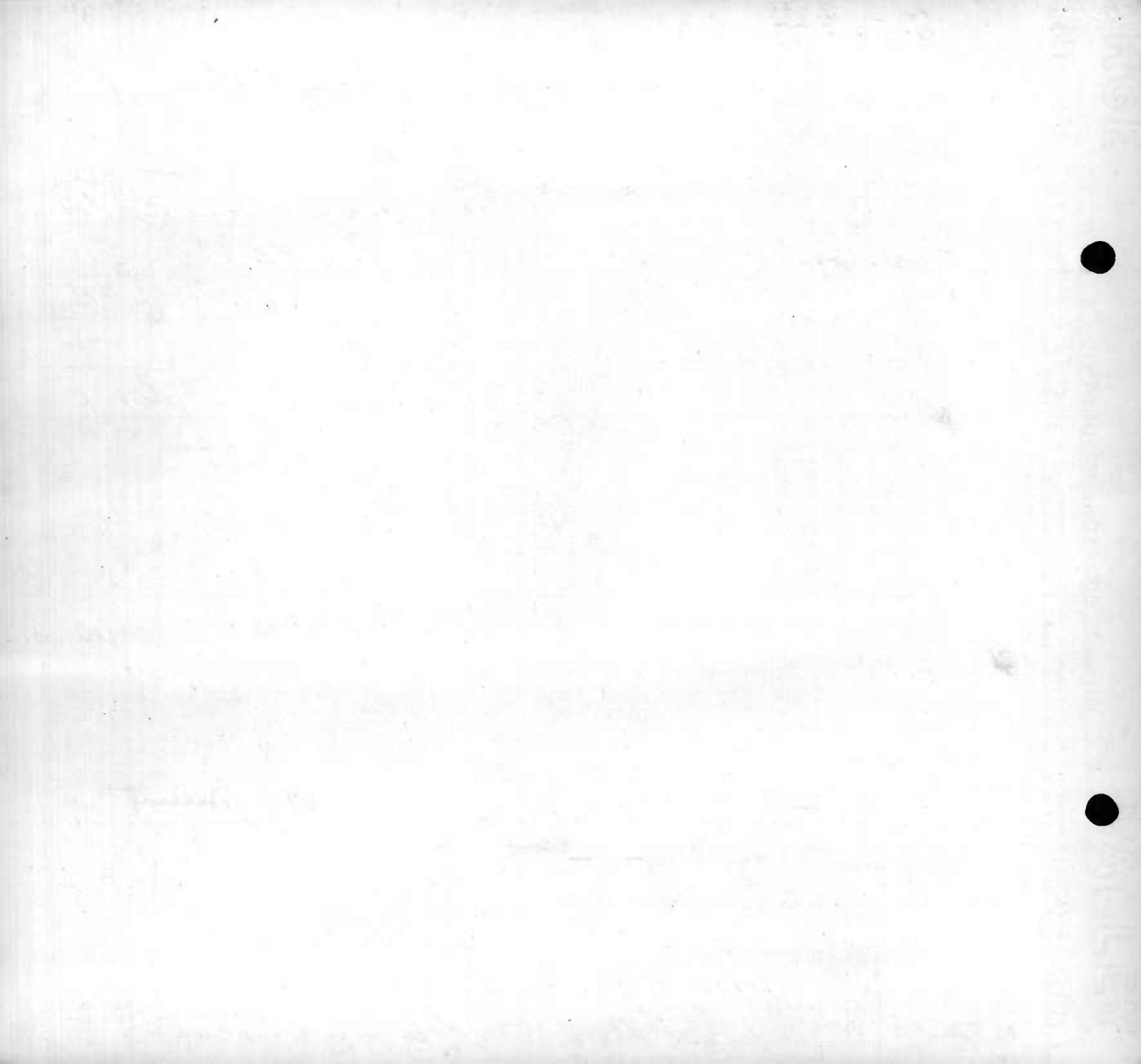
DECE

MA 14-4

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

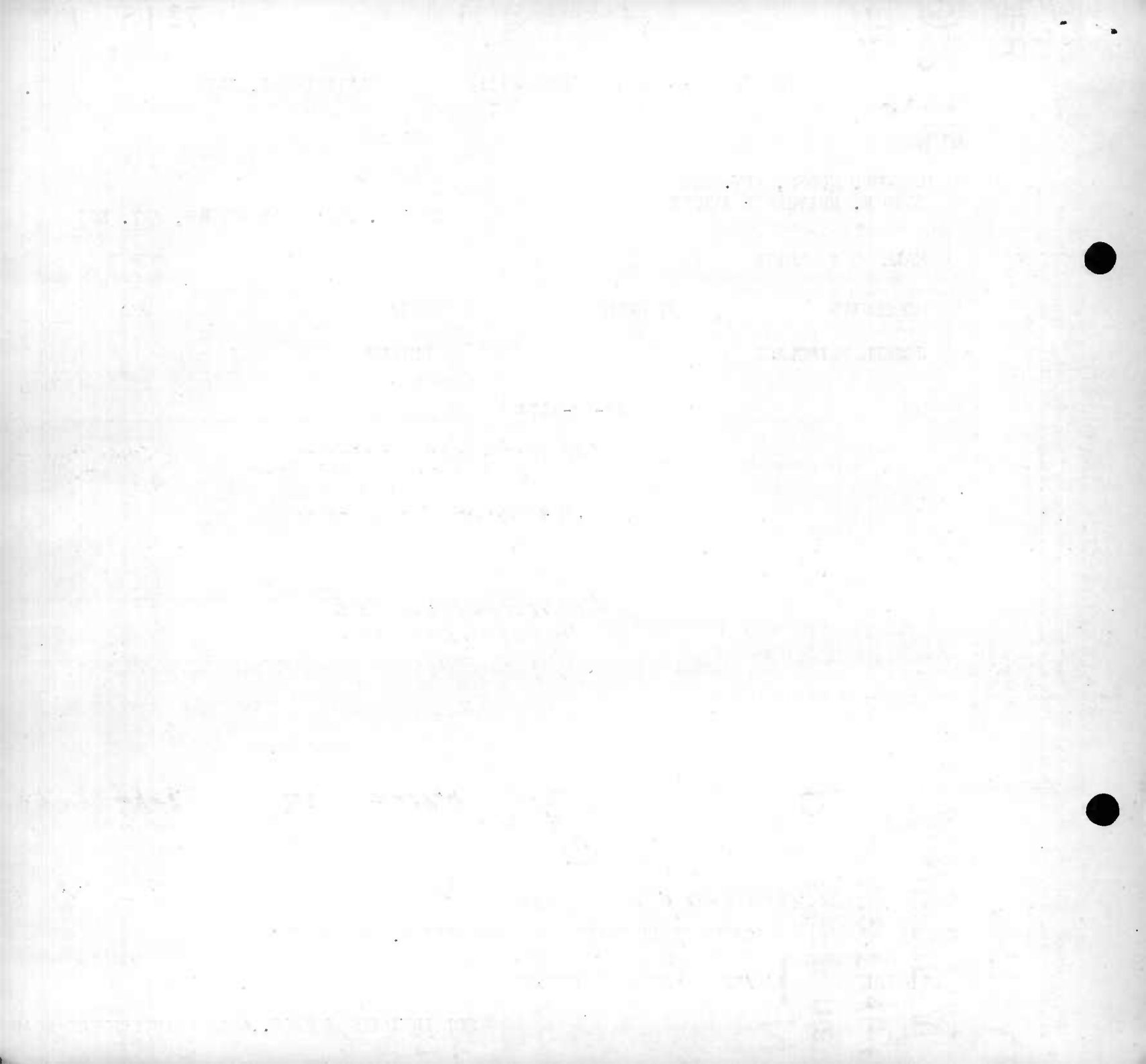
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08509	
W-516 72 08509				STATE OF MARYLAND-DENNE	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Sophia Wineberg		Sub Sept 2/72 6 P. M.		3707 Charles Lane apt A	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
3707 Charles Lane apt A		Md.		A. STATE B. COUNTY	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife		Home		Dec 12, 1888	
13. FATHER'S NAME		14. MOTHER'S MARIEN NAME		9. AGE (In years last birthday)	
George Nathan		Sarah		83	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				Jack Wineberg - Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cardiac Arrest	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		A.S.H.D. - Cardiac failure Years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes mellitus Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1969 to present 19 that (I) (we) last saw the deceased alive on 2 mo. ago 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Bernard Burgin M.D.				9/2/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
BERNARD BURGIN				3809 Clarks Lane	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/3/72		Beth El Memorial Park Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 6 1972		[Signature]		[Signature]	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08510	
G-651 R251 72 (8510) CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		BESSIE GREENBLATT (ROSENFELD)		2. DATE AND HOUR OF DEATH SEPTEMBER 1, 1972 5 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
CONCORD HOUSE, APT. 505 2500 W. BELVEDERE AVENUE			MARYLAND C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2500 W. BELVEDERE AVENUE, APT. 505		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		RUSSIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOSEPH FEINGLASS			ESTHER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		218-22-5174			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 183.5 + 250.9			TERMINAL GENERALIZED CARCINOMATOSIS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARINOMA OF COLON		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			DIABETES MELLITUS HYPOTHYROIDISM		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from March 1960 to 9-1-1972, that (1) (we) last saw the deceased alive on 8-29-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
JOSEPH DECKELBAUM				9-2-72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		3502 W. ROGERS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		9/3/72		SHAAREI TFILOH	
		24D. LOCATION (City, town, or county)		(State)	
		BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 6 1972		Sidney [Signature]		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08511</b>	
BIRTH NO. <b>B-633</b>		72 08511	
1. NAME OF DECEASED (Type or Print) <b>BROTMAN, ROBERT H.</b>		2. DATE AND HOUR OF DEATH <b>9/1/72 11:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI OF BALTIMORE, Hosp</b>		A. STATE <b>MARYLAND</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY <b>2740</b>	
5. SEX <b>MALE</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
6. RACE <b>XXX WHITE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		E. STREET AND NUMBER <b>5901 Park Heights Ave. #15.</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-16-36</b>	
9. AGE (In years last birthday) <b>36</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTAL</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>DENTIST</b>	
11. BIRTHPLACE (State or foreign country) <b>NEWARK, NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA AMERICAN</b>	
13. FATHER'S NAME <b>BENJAMIN BROTMAN</b>		14. MOTHER'S MAIDEN NAME <b>ROSA CASSAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. SADIE BROTMAN, 5901 PARK HEIGHTS AVE. #15</b>		ADDRESS	
18. <b>7-10-9 14250.9</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<b>Myocardial infarction</b>	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>Arteriosclerosis CVD</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		<b>9 days</b>	
(C) DUE TO, OR AS A CONSEQUENCE OF:		<b>8-10 m.</b>	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
<b>Diabetes mellitus</b>		<b>6-8 m.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from <b>8-24-72</b> to <b>9-2-72</b>	
that (I) (we) last saw the deceased alive on <b>9-1-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>[Signature]</b>	
23B. DATE SIGNED <b>9-2-72</b>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
BURIAL		9/3/1972	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BETH JACOB		FINKSBURG, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
SEP 6 1972		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
25C. FUNERAL DIRECTOR		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

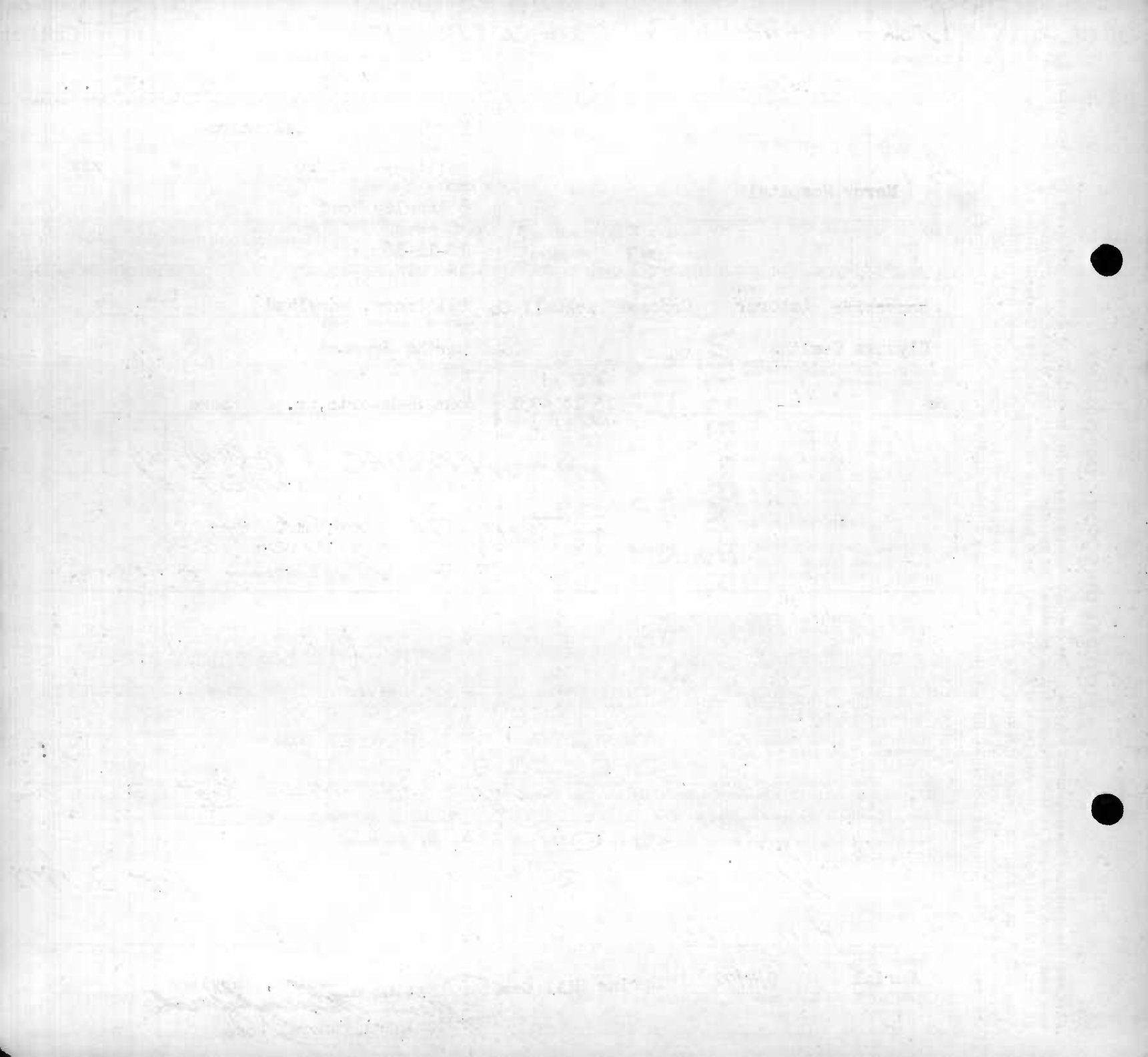
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 12 08512	
BIRTH NO. H-220		72 08512		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JESSIE HUGHES		2. DATE AND HOUR OF DEATH OF MARYLAND-DEATH 3 September 1972 5:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY Anne Arundel			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital 38 Baltimore, Md.		C. CITY OR TOWN Pasadena		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Typist		10B. KIND OF BUSINESS OR INDUSTRY Secretary		8. DATE OF BIRTH 9/7/00	
13. FATHER'S NAME Wilbur Harrison		14. MOTHER'S MAIDEN NAME May Roberts		9. AGE (In years last birthday) 71	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-474		17. INFORMANT Ruth Edwards 250 Glenwood Rd. Pasadena, Md.	
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CVA		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		20 HAS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3 SEPT 19 72 to 3 SEPT 19 72 that (we) last saw the deceased alive on 3 SEPT 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE Walker Robinson MD		23B. DATE SIGNED 3 SEPT 72		23C. PHYSICIAN'S NAME (Type) Walker Robinson MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/72		24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery	
24D. LOCATION Baltimore, City Maryland		24E. FUNERAL DIRECTOR Pasadena, Md.		24F. ADDRESS McCall's Funeral Homes Mt. & Tick Neck Rds.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR Dudley		25C. FUNERAL DIRECTOR McCall's Funeral Homes Mt. & Tick Neck Rds.	



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				72 08513		REG. NO. 72 08513	
BIRTH NO. B-326				72 08513			
1. NAME OF DECEASED (Type or Print) <b>Ruby Bedsworth</b>				2. DATE AND HOUR OF DEATH <b>9/3/72 17:50 p.m. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>				A. STATE <b>Maryland</b>		B. COUNTY <b>Baltimore</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore 21220</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>8 Langley Road</b>				5300			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-14-16</b>	
9. AGE (In years last birthday) <b>55</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ulysses Meekins</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Haywood</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No -</b>				16. SOCIAL SECURITY NO. <b>215 18 4731</b>		17. INFORMANT <b>John Bedsworth, Sr.</b>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC &amp; RESPIRATORY ARREST</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Terminal CANCER OF Ovary w/ metastasis to Abdomen</b> (C) <b>Advanced metastasis to Abdomen</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 30 1972</b> to <b>Sept 3 1972</b> , that (I) (we) lost saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I) (We) (did)</b> (did not) view the body after death.							
23A. SIGNATURE <b>Hwa Han M.D.</b>				23B. DATE SIGNED <b>Sept 3 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>HWA HAN</b>	
23D. ADDRESS <b>Mercy Hospital</b>				23E. FUNERAL DIRECTOR <b>Przdzinski Funeral Home</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/7/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Spring Hill Cemetery Extended</b>		24D. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Audrey [Signature]</b>		25C. ADDRESS <b>Przdzinski Funeral Home</b>			





## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>T-160</u> <u>72 08514</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 08514</u>	
1. NAME OF DECEASED (Type or Print) <u>Tobery, Baby Girl, Judy</u>				2. DATE AND HOUR OF DEATH <u>8/31/72</u> <u>1 7 50</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue, Baltimore, Md. 21224</u>				A. STATE <u>Md.</u>		B. COUNTY <u>Frederick</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Frederick</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>				6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>8/31/72</u>	
13. FATHER'S NAME <u>Thomas E. Tobery</u>				14. MOTHER'S MAIDEN NAME <u>Judy Marie Whittington</u>		9. AGE (In years last birthday) <u>13</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
17. INFORMANT <u>Records: BCH-4940 Eastern Ave. 21224</u>				12. CITIZEN OF WHAT COUNTRY?		10. AGE (In years last birthday) <u>13</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>776.21</u> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio-respiratory arrest</u>			
				(B) <u>Circulatory Collapse</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Bilateral Recurrent pneumothorax</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>8/31/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bilateral Chest tubes ctabare</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> 19 <u>72</u> to <u>8/31</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/31</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Marie C. McCormick M.D.</u>				23B. DATE SIGNED <u>8/31/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>Marie C. McCormick</u>				23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Md. 21224</u> <u>Baltimore City Nursery</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept 2, 1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Middletown, Lutheran Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Middletown, Frederick, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1972</u>		25B. NAME OF REGISTRAR <u>Lidney Johnson</u>		25C. FUNERAL DIRECTOR <u>Smith, Padeley, Keeney, Basford</u> <u>106 E. Church St., Frederick, Md. 21701</u>			

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1. 1950-1951: 1950

1950-1951

1950-1951

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1950-1951

**FUNERAL DIRECTOR: IMPORTANT**

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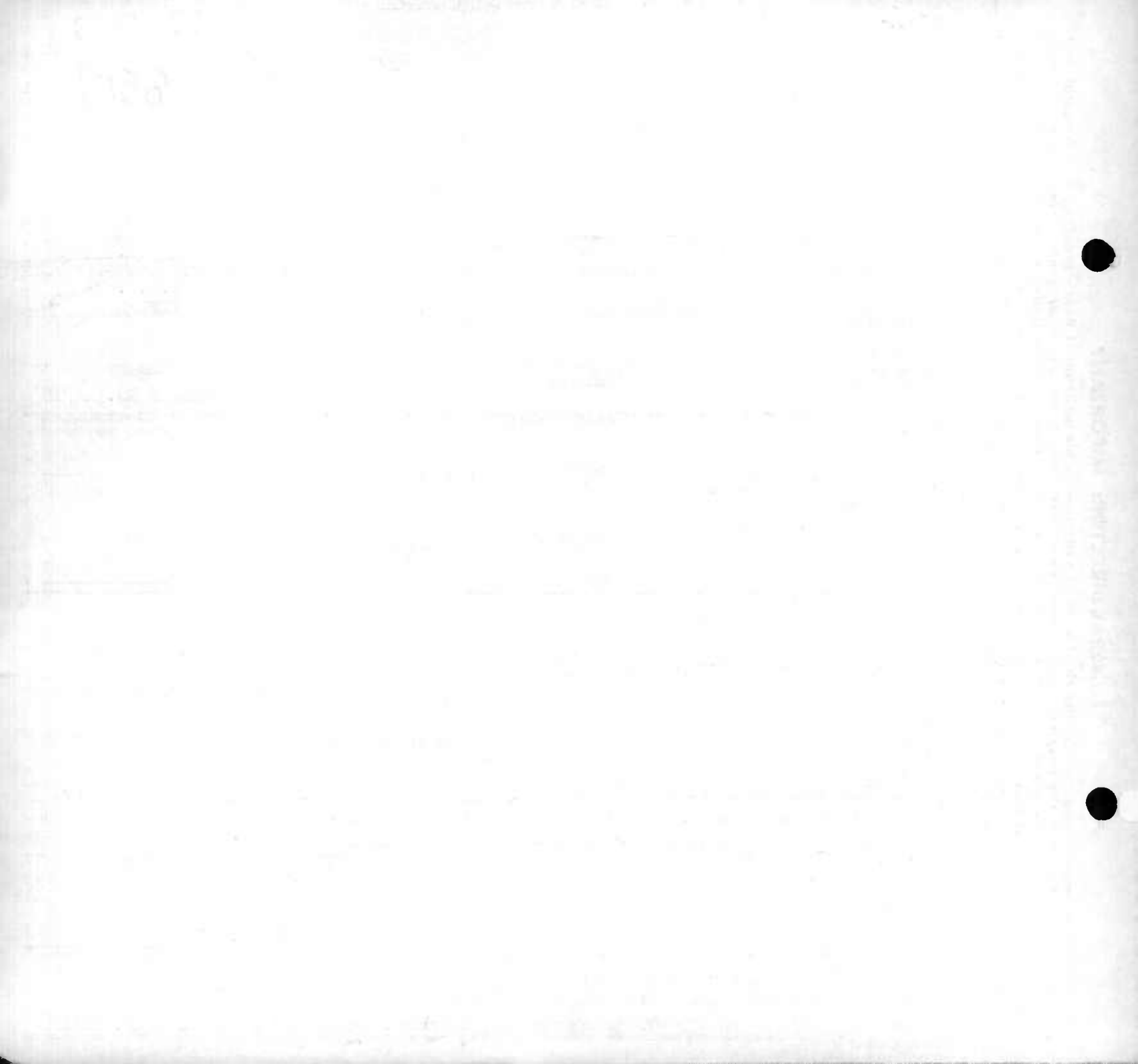
<p><b>S-100</b>      <b>72 08515</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 08515</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>SWOPE, RUTH ALLENE</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>U.S. Public Health Service Hospital</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>9-4-72 11:41 A.M.</b></p>	
<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b></p>		<p><b>5. CITY OR TOWN</b> <b>BALTIMORE</b> <b>841</b></p>	
<p><b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		<p><b>7. STREET AND NUMBER</b> <b>3311 Lyndale Avenue</b></p>	
<p><b>8. SEX</b> <b>F</b></p>	<p><b>9. RACE</b> <b>C</b></p>	<p><b>10. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>11. DATE OF BIRTH</b> <b>4-24-24</b> <b>4-24-1924</b></p>
<p><b>12. AGE</b> (In years lost birthday) <b>48</b></p>		<p><b>13. If Under 1 Yr. Months: Days: Hours: Min.</b></p>	
<p><b>14. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b></p>		<p><b>15. BIRTHPLACE</b> (State or foreign country) <b>West Virginia</b></p>	
<p><b>16. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>		<p><b>17. FATHER'S NAME</b> <b>Wilbur Curkendoll</b></p>	
<p><b>18. MOTHER'S MAIDEN NAME</b> <b>MAUDE BREAK</b></p>		<p><b>19. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>	
<p><b>20. SOCIAL SECURITY NO.</b> <b>—</b></p>		<p><b>21. INFORMANT</b> <b>PATIENT CHART</b></p>	
<p><b>22. CAUSE OF DEATH</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p><b>(A) IMMEDIATE CAUSE</b> <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(B) PULMONARY METASTASES</b> DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p><b>(C) ADENOCARCINOMATOSIS, PRIMARY UNKNOWN</b> DUE TO, OR AS A CONSEQUENCE OF:</p>		<p><b>MINUTES</b> <b>WEEKS</b> <b>MONTHS</b></p>	
<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p><b>19A. DATE OF OPERATION</b> <b>2-1-72</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <b>YES</b></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>YES</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (X) (this hospital) attended the deceased from 8-14 1972 to 9-4 1972, that (X) (we) last saw the deceased alive on 9-4 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>Robert H. Kirschner MD.</b></p>		<p><b>23B. DATE SIGNED</b> <b>9-4-72</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>ROBERT H. KIRSCHNER MD.</b></p>		<p><b>23D. ADDRESS</b> <b>U.S. Public Health Service Hospital</b> <b>3100 Wyman Park Drive</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Removal</b></p>		<p><b>24B. DATE</b> <b>9/5/72</b></p>	
<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Lorentz</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Upshur, West Virginia</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 6 1972</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>Robert C. Altenburg</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <b>Robert C. Altenburg Funeral Home, Inc.</b></p>		<p><b>ADDRESS</b> <b>6009 Harford Rd. Balto., Md. 21214</b></p>	

9-11-1972 - Birth Certificate of Ruth Allene Curkendoll, born April 24, 1928, Buckhannon,  
W. Va. Father-Calvin Wilbert Curkendoll, Mother's Maiden Name-Made Curkendoll.  
Certificate No. 17226 HRS  
Affidavit of Husband, August J. Swope.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				STATE OF MARYLAND - DEMO	
<div style="font-size: 2em; font-weight: bold;">S-152</div> <div style="font-size: 1.5em; font-weight: bold;">12 08516</div>		<div style="font-size: 1.5em; font-weight: bold;">RUTH L. SPANGLER</div>		<div style="font-size: 1.5em; font-weight: bold;">72 08516</div>	
<div style="font-size: 1.5em; font-weight: bold;">RUTH LOIS SPANGLER</div>					
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Md.</i>	
4. SEX <i>Female</i>		6. RACE <i>Caucasian</i>		8. DATE OF BIRTH <i>28 Feb 29</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>45</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Telephone Company</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Harry R. Bull</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Loudon</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Richard H. Spangler, 3711 Elkader Rd. 21218</i>	
<div style="font-size: 1.5em; font-weight: bold;">18. CAUSE OF DEATH</div>				<div style="font-size: 1.5em; font-weight: bold;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div>	
<div style="font-size: 1.5em; font-weight: bold;">I</div>				<div style="font-size: 1.5em; font-weight: bold;">(A) IMMEDIATE CAUSE</div>	
<div style="font-size: 1.5em; font-weight: bold;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div>				<div style="font-size: 1.5em; font-weight: bold;">DUE TO, OR AS A CONSEQUENCE OF:</div>	
<div style="font-size: 1.5em; font-weight: bold;">ANTECEDENT CAUSES</div>				<div style="font-size: 1.5em; font-weight: bold;">(B) DUE TO, OR AS A CONSEQUENCE OF:</div>	
<div style="font-size: 1.5em; font-weight: bold;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</div>				<div style="font-size: 1.5em; font-weight: bold;">(C)</div>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR	
22. I certify that (1) (this hospital) attended the deceased from <i>2 September 1972</i> to <i>3 September 1972</i>		that (1) (we) lost saw the deceased olive on <i>3 September 1972</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>[Signature]</i>		23B. DATE, SIGNED <i>3 September 1972</i>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<i>burial</i>		<i>6 Sept 72</i>		<i>Meadow Ridge Memorial Park</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 6 1972</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>Ullrich Funeral Home, Dundalk, Md. 21222</i>	

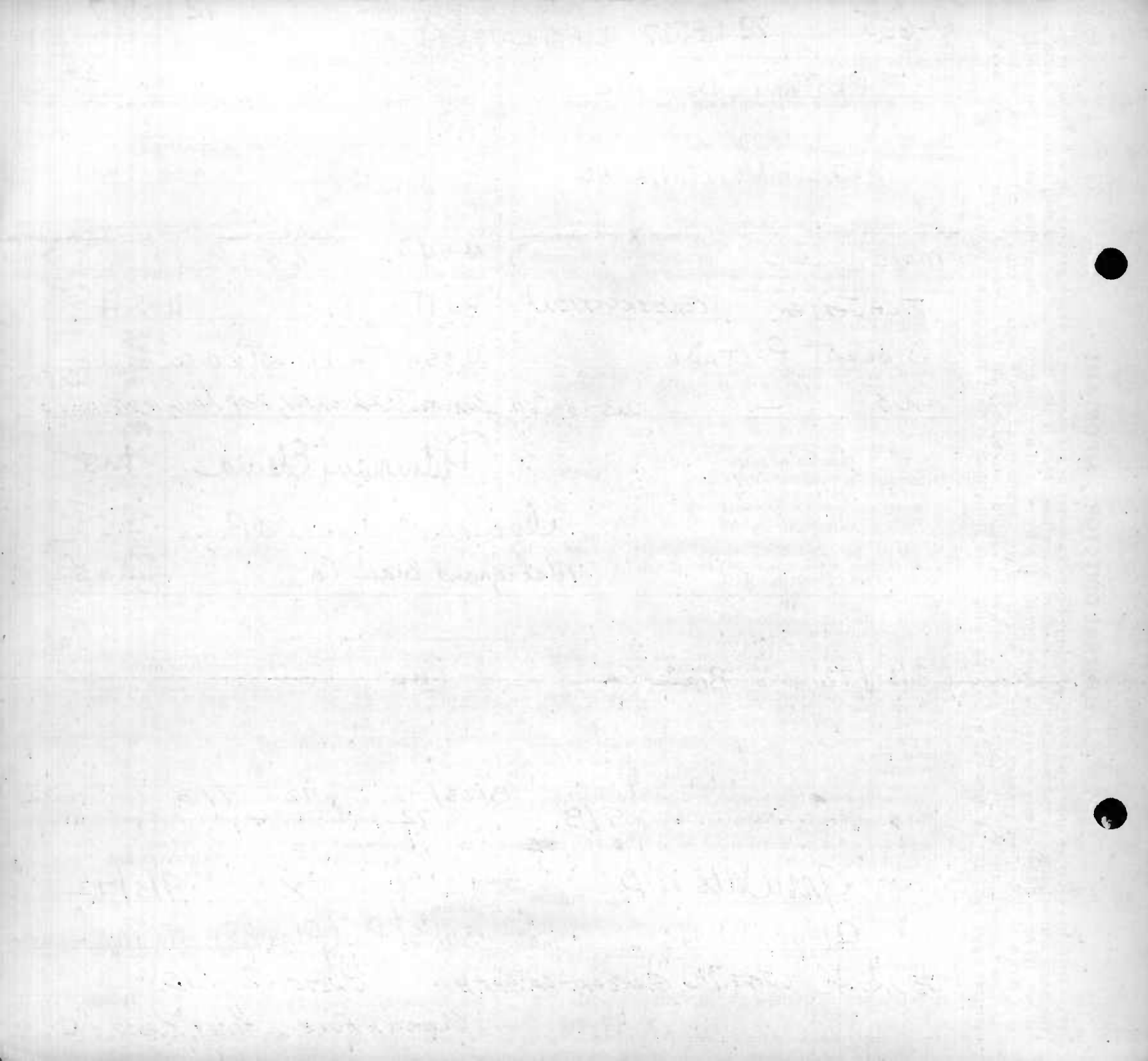


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-635 72 08517		72 08517		CERTIFICATE OF DEATH		72 08517	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO. STATE OF MARYLAND-DEMD	
		PROTANI, Dominic		9-3-72 1 355 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
Mercy Hospital, Q.N.C.				Md.		2632	
37				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				5210 Sipple Ave			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days	11. UNDER 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY?
male	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-14-12	60			U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
TILE SETTER		CONSTRUCTION		Balto, Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Vincent PROTANI				Assunta Mastracci			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		213-16-5611		DANIEL D. PROTANI, 809 Mockingbird Ln.		2204	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Pulmonary Edema		hrs.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Increased intracranial Pressure		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Malignant Brain Ca				months.	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
8/31/72		Brain Ca		no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 8/23/- 19 72 to 9/3 19 72, that (we) last saw the deceased alive on 9/3 19 72 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Glenn Wells MD				9/3/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Glenn Wells MD				301 St. Paul Place Balto, Md. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		6 SEP 72		GARDEN OF FAITH		BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 6 1972		[Signature]		GLENN H. FUNKEL, BALTO, MD.			



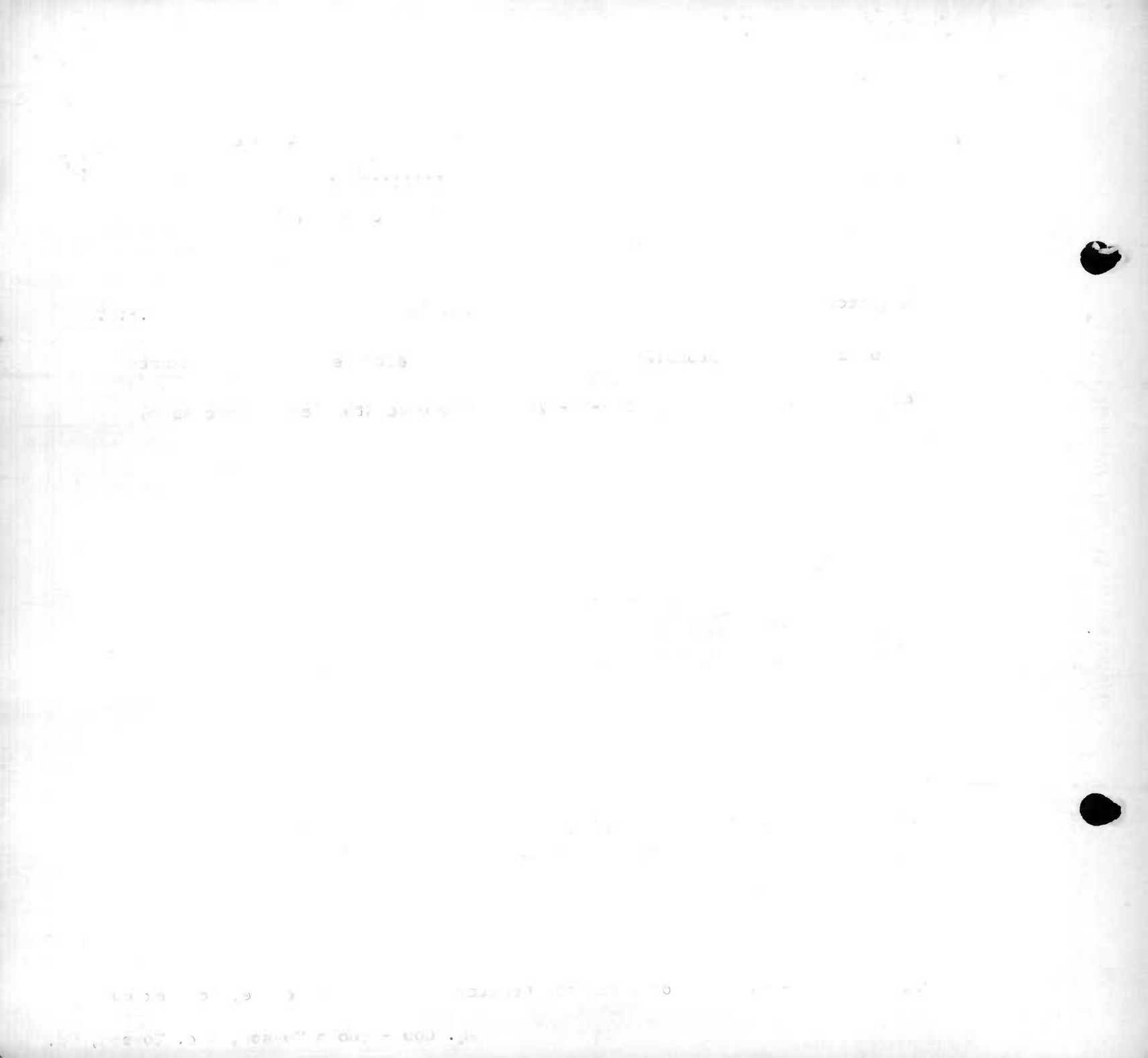




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 08518	
<div style="display: flex; justify-content: space-between;"> <span>S-351</span> <span>72 08518</span> </div>				<b>CERTIFICATE OF DEATH</b>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="margin-left: 100px;">STOMBLER</span> <span style="margin-left: 50px;">JEROME J.</span>				<b>2. DATE AND HOUR OF DEATH</b> September 1, 1972 10:30 a.m.	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL of Baltimore, Inc. Belvedere Ave. at Greenspring 21215				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Timonium D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 16 Hataway Road	
<b>5. SEX</b> Male	<b>6. RACE</b> White	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 6-4-23	<b>9. AGE</b> (In years last birthday) 49	If Under 1 Yr. Months: Days: Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Engineer		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> General motor		<b>11. BIRTHPLACE</b> (State or foreign country) Maryland <b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> Louis Stomblor			<b>14. MOTHER'S MAIDEN NAME</b> Gertrude Swartz		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		<b>16. SOCIAL SECURITY NO.</b> 219-18-5798	<b>17. INFORMANT</b> Florence Stomblor Same as #4		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer of Pancrease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> 3 M.					
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (H) (this hospital) attended the deceased from Aug 19 1972 to Sept 1 1972 that (H) (we) last saw the deceased alive on Sept 1 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> Srisook Boonsuei M.D.				<b>23B. DATE SIGNED</b> 9-1-72	
<b>23C. PHYSICIAN'S NAME</b> (Type) SRI SOOK BOONSUEI M.D.				<b>23D. ADDRESS</b> Sinai Hospital of Baltimore, Inc.	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> 9-5-72		<b>24C. NAME OF CEMETERY or CREMATORY</b> Mount Calvary Cemetery	
<b>24D. LOCATION</b> (City, town, or county) (State) Albuquerque, New Mexico		<b>25A. DATE REC'D BY HEALTH DEPT.</b> SEP 8 1972			
<b>25B. NAME OF REGISTRAR</b>		<b>25C. FUNERAL DIRECTOR</b> Wm. Cook-Brooks Towson, Inc. Towson, Md.			



# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>S-616</span> <span>72 08519</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.2em;">72 08519</span> STATE OF MARYLAND-DEPT	
BIRTH NO. <span style="font-size: 1.2em;">1</span> 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Carl W. Scarborough</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">Sept. 2, 1972</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">37</span> <span style="font-size: 1.2em;">Mercy Hospital</span>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.5em;">2748</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">5907 Glenkirk Rd. -21239</span>	
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Dec. 14, 1903</span>
9. AGE (In years (last birthday)) <span style="font-size: 1.2em;">68</span>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired Postman</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">U.S. Govt.</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Balto. City</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Oscar Scarborough</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Emily Robinson</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <span style="font-size: 1.2em;">Mrs. Kathryn A. Scarborough</span>		ADDRESS <span style="font-size: 1.2em;">-5907 Glenkirk</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">Bronchopneumonia, etc.</span>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">9 mos.</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">9-5-72</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">November 29</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">Sept. 2</span> 19 <span style="font-size: 1.2em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Aug 29</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Wm. H. Grenzer, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">9.3.72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">WM. H. GRENZER, M.D.</span>		23D. ADDRESS <span style="font-size: 1.2em;">2119 POT SPRING RD.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9-5-72</span>	
24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Parkwood Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto. Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 6 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Audrey Thornton</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">John C. Miller Inc.</span>		ADDRESS <span style="font-size: 1.2em;">6415 Belair Rd. -21206</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>ADS</span> <span>G-200</span> <span>72 08520</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>72 08520</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 72 08520</span> </div>	
BIRTH NO. <span style="font-size: 1.5em;">G-200</span> 1. NAME OF DECEASED (Type or Print) <b>GUESS, FLETCHER HOLLMAN</b>		2. DATE AND HOUR OF DEATH <b>SEPTEMBER 3, 1972 4:12P.M.</b> STATE OF MARYLAND-DENOTED	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">40</span> <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUES BALTIMORE, MARYLAND 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> 8. COUNTY <b>BALTIMORE COUNTY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1250 VOGT AVENUE</b>	
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04 04 16</b> 9. AGE (In years last birthday) <b>56</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NATIONAL CAN CORPORATION</b>	11. BIRTHPLACE (State or foreign country) <b>FLORIDA</b>
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>FLETCHER GUESS</b>	
14. MOTHER'S MAIDEN NAME <b>RUBY (JENNINGS)</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR 11</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL MEDICAL RECORDS</b>	
18. <span style="font-size: 1.5em;">4319 I</span> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute pulmonary edema</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Massive cerebral hemorrhage</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XI</u> (this hospital) attended the deceased from <u>AUGUST 31</u> 19 <u>72</u> to <u>SEPTEMBER 3</u> 19 <u>72</u> , that <u>XI</u> (we) last saw the deceased alive on <u>SEPTEMBER 3</u> 19 <u>72</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) <u>XXXXX</u> view the body after death.			
23A. SIGNATURE <b>Vincent H. Wang MD.</b>		23B. DATE SIGNED <b>09/04/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>VINCENT H WANG MD</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL BALTO MD 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>9/5/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Audrey M. Brown</b>	
25C. FUNERAL DIRECTOR <b>Ambrose Inc.</b>		ADDRESS <b>1328 Sulphur Sp. Rd.</b>	

4-12P

SEPTEMBER 3, 1972

GUESS, FLETCHER POLINA

BALTIMORE COUNTY MD

BALTIMORE  
1250 POST AVENUE

ST. AGNES HOSPITAL  
WILKINS & CATON AVENUES  
BALTIMORE, MARYLAND 21229

XX

04 04 15 26

MALE CAUCASIAN

NATIONAL CAN  
CORPORATION

INSPECTOR

RUBY (JENNINGS)

FLETCHER GUESS

ST. AGNES HOSPITAL MEDICAL RECORDS

YES WORLD WAR II

YES

SEPTEMBER 3 72

AUGUST 31

XX

SEPTEMBER 3 72

XXXXXX

09/04/72

X

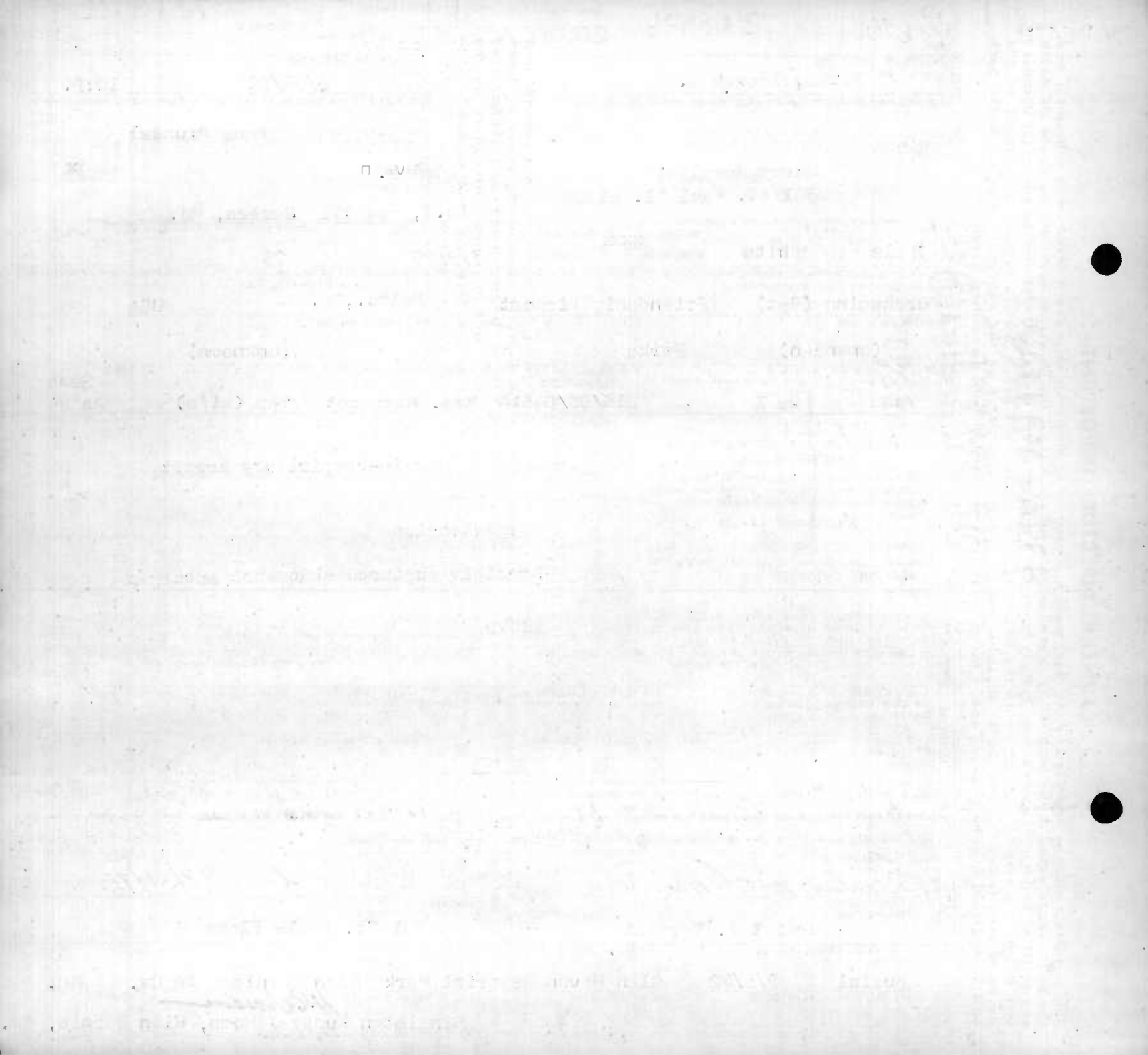
ST. AGNES HOSPITAL BALTO MD 21229

VINCENT H WANG MD

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620		72 08521		BALTIMORE CITY HEALTH DEPARTMENT		72 08521	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Parks, Thomas A.				2. DATE AND HOUR OF DEATH 8/31/72 10:P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital 301 St. Paul Pl. 21202		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Maryland Severn		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER Rt. 3, Box 171 Severn, Md.							
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/99	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing (Ret)		10B. KIND OF BUSINESS OR INDUSTRY Friendship Airport		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (unknown) Parks				14. MOTHER'S MAIDEN NAME (unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216/05/6461A		17. INFORMANT Mrs. Margaret Parks (wife)		ADDRESS Same As #4	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD				(A) IMMEDIATE CAUSE Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) Possible ruptured abdominal aneurysm			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (b) (this hospital) attended the deceased from 8:31 1972 to 8:31 1972, that (b) (we) lost saw the deceased alive on 8:31 1972 and that in (b) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (We) (did not) view the body after death.							
23A. SIGNATURE Benedict A. Termini				23B. DATE SIGNED 8/31/72		23C. PHYSICIAN'S NAME (Type) Benedict A. Termini	
23D. ADDRESS 301 St. Paul Place				23E. ADDRESS 301 St. Paul Place			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/5/72		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie AA Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR Hidney		25C. FUNERAL DIRECTOR Singleton		ADDRESS Singleton Funeral Home, Glen Burnie, Md.	

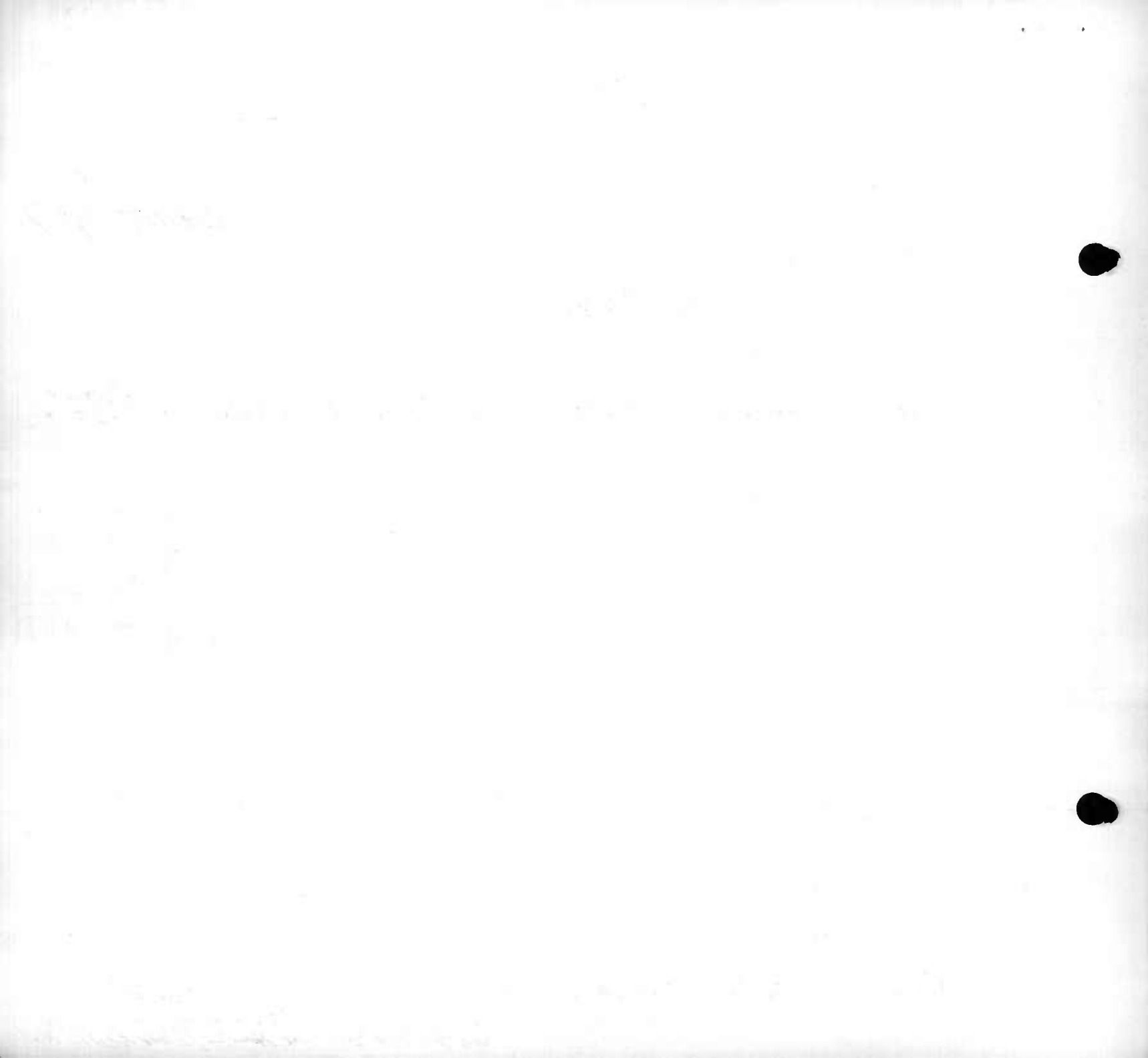




# FUNERAL DIRECTOR: IMPORTANT

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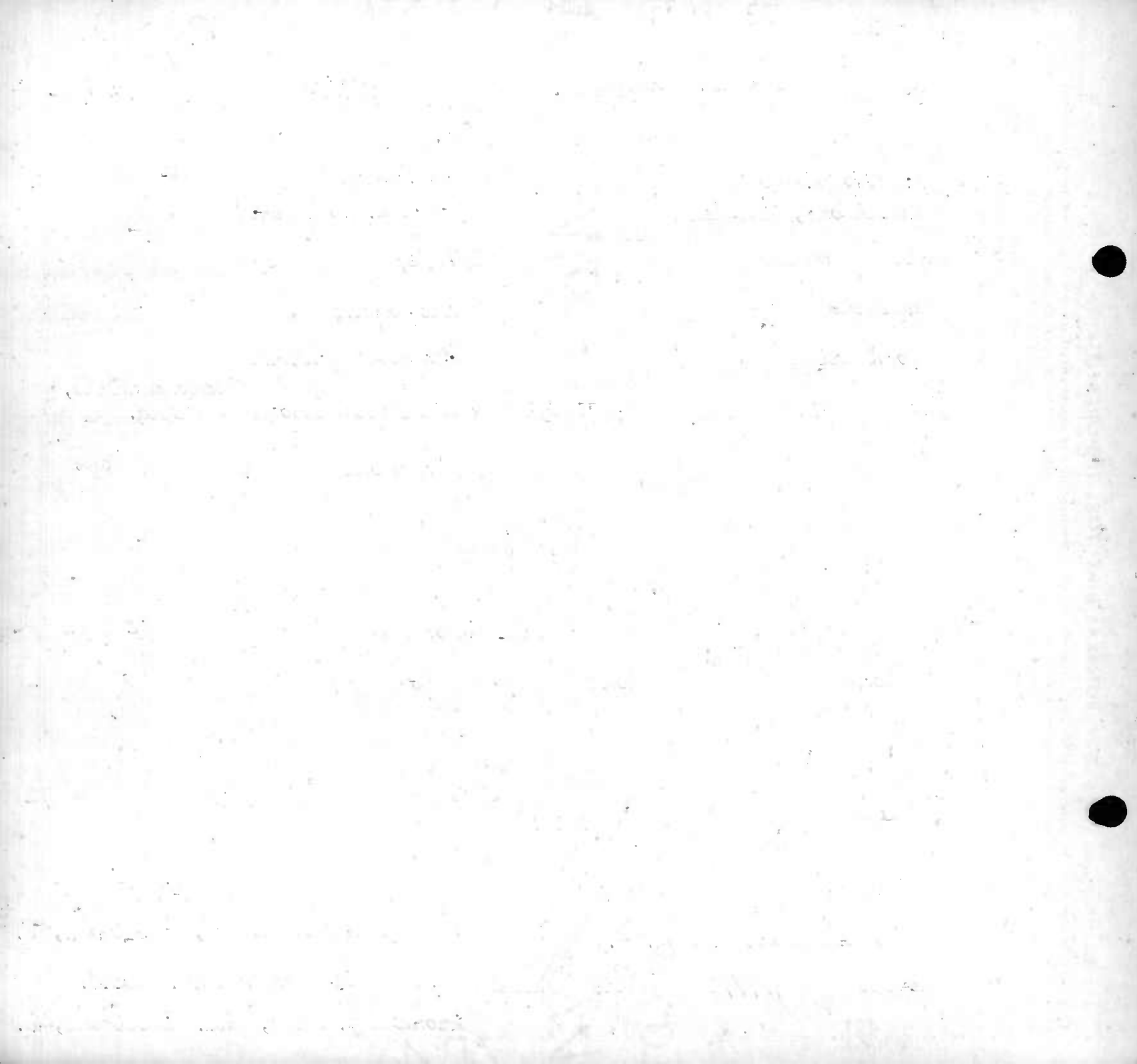
L-516		72 08522		BALTIMORE CITY HEALTH DEPARTMENT		72 08522	
BIRTH NO.		72 08522		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>LEINEWEBER, RICHARD</b>				2. DATE AND HOUR OF DEATH <b>9-3-1972 7:40 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>				A. STATE <b>M.A.</b> B. COUNTY <b>M.A.</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>GLEN BURNIE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>				6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gen'l Motors</b>		8. DATE OF BIRTH <b>5-17-1899</b>		9. AGE (In years last birthday) <b>73</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>AUGUST LEINEWEBER</b>				14. MOTHER'S MAIDEN NAME <b>KATY HETCHEN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>313-10-771</b>		17. INFORMANT <b>Mrs. Evelyn M. LeineWEBER (wife)</b>		ADDRESS <b>5200</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>PROSTATIC GLAND HYPERTROPHY</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>MITRALL INSUFFICIENCY.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC CEREBROVASCULAR</b> (C) <del>DISEASE - OLD LEFT HEMIPARESIS</del>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>W</b> (this hospital) attended the deceased from <b>9-2-1972</b> 19 <b>72</b> to <b>9-3</b> 19 <b>72</b> that (I) <b>W</b> last saw the deceased alive on <b>9-3-1972 - 0:15 A.M.</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <b>W</b> (did) (did not) view the body after death.							
23A. SIGNATURE <b>Julij Tosheff, M.D.</b>				23B. DATE SIGNED <b>9-3-1972</b>			
23C. PHYSICIAN'S NAME (Type) <b>JULIJ TOSHEFF, M.D.</b>				23D. ADDRESS <b>2025-Woodbourne Ave, Baltimore, Md. 21239</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9/6/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Lidney Johnston</b>		25C. FUNERAL DIRECTOR <b>Spigdeten Funeral Home, Glen Burnie Md.</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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W-623 72 08523				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08523	
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lawrence Wright</i>				2. DATE AND HOUR OF DEATH <i>9/4/72 5:11 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>USPH Hospital</i> <i>Baltimore, Maryland</i>				A. STATE <i>Md.</i>		B. COUNTY <i>BALTO</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>male</i>				6. RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>6/16/87</i>				9. AGE (In years last birthday) <i>85</i>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>John Wright</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Shimel</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>111 1</i>		17. INFORMANT <i>Heath Funeral Home</i>	
18. <i>486A I</i>				CAUSE OF DEATH		ADDRESS <i>Osceola Mills, Penna.</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 Days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Acute Parotitis</i>						<i>18 Days</i>	
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/28/72</i> 19 <i>72</i> to <i>9/4/72</i> 19 <i>72</i> . that (I) (we) last saw the deceased alive on <i>9/4/72</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert Stone Baxt M.D.</i>						23B. DATE SIGNED <i>9/4/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert Stone Baxt M.D.</i>						23D. ADDRESS <i>3100 Wyman Park Drive, Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/7/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Umbria Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Decatur Twnshp. Penna.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 6 1972</i>		25B. NAME OF REGISTRAR <i>Sidney H. Hinton</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>Baltimore, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

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A-536 72 08524				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08524	
BIRTH NO.				STATE OF MARYLAND-DEPT.			
1. NAME OF DECEASED (Type or Print) <b>Mary Louise Anderson</b>				2. DATE AND HOUR OF DEATH <b>Sept. 1, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>337 East 29th. St.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>337 E. 29 th. Street</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 11, 1899</b>	9. AGE (In years lost birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Roundhill, Virginia</b>	
13. FATHER'S NAME <b>William Poston</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-14-4908</b>		17. INFORMANT <b>Mr. Clemence G. Anderson same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4/12/21</b> <b>HASCVD - 12 yrs.</b> <b>As discussed with medical examiner's office</b> <b>Sudden</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 62</b> to <b>Sept 1 19 72</b> , that (we) last saw the deceased alive on <b>Sept 1 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Herman Brecher M.D.</b>				23B. DATE SIGNED <b>9/2/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Herman Brecher, M.D.</b>				23D. ADDRESS <b>6410 Windsor Mill Rd Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/5/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Baltimore, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-620		72 08525		BALTIMORE CITY HEALTH DEPARTMENT		12 08525	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOSEPH T. JIRSA				Sept. 2 <sup>nd</sup> 1972 07:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
The Union Memorial Hospital				Maryland. 2734			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				Hamilton Avenue 3807			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		03-06-98 74	
						9. AGE (In years lost birthday) 74	
						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
						Houlster Ret.	
						11. BIRTHPLACE (State or foreign country)	
						Maryland	
						12. CITIZEN OF WHAT COUNTRY?	
						U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOSEPH JIRSA				JOSEPHINE Juda			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
XXXXXX no				217-60-4756		Chart Mrs. Mary M. Jirsa same	
18. 410.9 I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Acute Myocardial Infarction 3 hr			
ANTECEDENT CAUSES				(B) Arteriosclerotic cardiovascular disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
08-31-72		(R) Inguinal hernia (corrected)		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
No							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 08-29-1972 to 09-02-1972, that (I) (we) last saw the deceased alive on 09-02-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
CESAR A. ALEGRE				09-02-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CESAR A. ALEGRE				The Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/6/72		Gardens of Faith		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 6 1972		Sidney J. Jirsa		Leonard J. Ruck Inc.		Balto. Md.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08526		72 08526	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH STATE OF MARYLAND - DUMFRIES	
		George John Adelhardt, Jr.		Sept. 1, 1972 9:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
US Public Health Service Hospital 3100 Wyman Parkway			Md. BALTO 5300		
5. SEX M			6. RACE Caucasian		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10/30/29		
9. AGE (In years last birthday) 42			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Data system analyst		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George John Adelhardt, Sr.			14. MOTHER'S MAIDEN NAME Barbara McCart		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1951-1953			16. SOCIAL SECURITY NO. 216-24-5711		
17. INFORMANT Records- US PHS Hospital, Balto, Md.			ADDRESS		
18. 205.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Several Days			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. 205.0 II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myelocytic leukemia (B) DUE TO, OR AS A CONSEQUENCE OF: Months			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Apr. 13 19 72 to Sept. 1 19 72, that (I) (we) last saw the deceased alive on Sept. 1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John E. Sutherland, MD					23B. DATE SIGNED 9/1/72
23C. PHYSICIAN'S NAME (Type) John Sutherland, MD					23D. ADDRESS US PHS Hospital, Balto, Md. 21211
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/6/72		24C. NAME OF CEMETERY or CREMATORY Gettysburg National Cemetery Gettysburg Pa	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR Lassan Funeral Home 7401 Belair Rd. Balto.			
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR Lassan Funeral Home		25C. FUNERAL DIRECTOR Lassan Funeral Home	

3508 Labeled Form

4/12/21

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08527	CERTIFICATE OF DEATH		REG. NO. 72 08527	STATE OF MARYLAND-DEM	
1. NAME OF DECEASED (Type or Print) <u>Goldie A. Kessler</u>				2. DATE AND HOUR OF DEATH <u>August 31, 1972</u> <u>7:00 P.</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6104 Everall Avenue</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1903</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Louden Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Harvey</u>			14. MOTHER'S MAIDEN NAME <u>Josephine Mossberg</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>220-34-5630</u>			17. INFORMANT ADDRESS <u>Mrs. Irene Dilworth 6104 Everall Ave.</u>						
18. <u>412.4</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Atherosclerotic Cardiac</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Vasculum Disease</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Vasculum Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>X</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> <u>1961</u> to <u>31 Aug</u> <u>1972</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>16 Aug</u> <u>1972</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <u>John C. Hylle</u>				23B. DATE SIGNED <u>9-1-72</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHN C. HYLLE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>9/5/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore City, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1972</u>				25B. NAME OF REGISTRAR <u>Sidney W. Hylle</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Lassahn Funeral Home 7401 Belair Rd.</u>			

John G. H.C.  
April 6, 1910

X

NO

2231 Belmont Ave. Chicago, Ill.  
P. 100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08528</b>	
M-220 72 08528		72 08528	
1. NAME OF DECEASED (Type or Print) <b>LENA MAKOWSKI</b>		2. DATE AND HOUR OF DEATH <b>AUG. 28 1972</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CHURCH HOME AND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>203</b>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEP 19 1899</b>	
9. AGE (In years last birthday) <b>72</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN JANKOWIAK</b>		14. MOTHER'S MAIDEN NAME <b>ROSALIE JANKA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>2709-9238</b>	
17. INFORMANT <b>BERNARD CZYZEWSKI</b>		ADDRESS <b>116 SACRED HEART</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF:			
(B) <b>18 Hrs C.H.F. &amp; M.S.-AS</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>20 yrs</b>	
(C) <b>cardiomegaly</b>		<b>20 yrs</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> 19 <b>71</b> to <b>6/7</b> 19 <b>71</b> and that (I) (we) lost saw the deceased alive on <b>6/7</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE <b>Joseph D. Antonio</b>		23B. DATE SIGNED <b>8/30/72</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Raymond L. Kaczorowski</b>	
25C. FUNERAL DIRECTOR		ADDRESS <b>2525 FLEET ST</b>	

9-25-1972 - Correction form from Funeral Home-Raymond L. Kaczorowski, Balto., Md.

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 08529</b> STATE OF MARYLAND-DEMH	
K-420 72 08529 BIRTH NO.		72 08529	
1. NAME OF DECEASED (Type or Print) <b>KULESZA, Mrs. ALICE</b>		2. DATE AND HOUR OF DEATH <b>9/2/72 1AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital BALTIMORE, Md 21231</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>103</b>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-8-91</b> 9. AGE (In years last birthday) <b>80</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>AMER</b>	
13. FATHER'S NAME <b>JOSEPH KAWALEK</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219 057217</b>	
17. INFORMANT <b>Mrs CATHERINE SZCZEPANIAK</b>		ADDRESS <b>675 6215 406 W. LINWOOD</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>202.1 progressive Congestive Failure (Heart)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized wasting, Bone?</b>		DUE TO, OR AS A CONSEQUENCE OF: <b>7 yrs?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ASMP</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6/30/1972</b> to <b>9/2/1972</b> that (I) (we) last saw the deceased alive on <b>9/2/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>L. PADMARAJU MD</b>		23B. DATE SIGNED <b>9/1/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>L. PADMARAJU MD</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/6/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE C. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Horton</b>	
25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>		ADDRESS <b>1525 FLEET ST.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08530	
72 08530 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH	
BIRTH NO. <u>S-354</u>		1. NAME OF DECEASED (Type or Print) <u>JOHN STANLEY</u>		2. DATE AND HOUR OF DEATH <u>8-31-72</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>0024 N. LINWOOD AVE.</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>601</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>24 N. LINWOOD AVE</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/95</u>	9. AGE (in years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. L. EMELINE CONNELLY</u>	
		ADDRESS <u>24 N. LINWOOD AVE</u>			
18. <u>428X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTCEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Heart Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (C) <u>Edema of Lungs</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>3 mo.</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 10 - 19 72</u> to <u>Aug 31 19 72</u> and that (I) (we) last saw the deceased alive on <u>Aug 10 19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William G. Geyer, M.D.</u>				23B. DATE SIGNED <u>Sept. 5-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>W.M. G. GEYER, M.D.</u>				23D. ADDRESS <u>156 N. Melton Ave Balto-Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/6/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART JESUS</u>	
24D. LOCATION <u>BALTIMORE MD.</u>		24E. NAME OF REGISTERED FUNERAL DIRECTOR <u>RAYMOND KACZOROWSKI</u>		24F. ADDRESS <u>2525 FLEET ST.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1972</u>		25B. NAME OF REGISTRAR <u>Disposition</u>		25C. FUNERAL DIRECTOR <u>RAYMOND KACZOROWSKI</u>	



72 08531		BALTIMORE CITY HEALTH DEPARTMENT		72 08531	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>ISAAC (ISSAC) WOODARD</u>			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital (DOA)</u>			3. DATE PRONOUNCED DEAD Month Day Year Hour <u>9 3 1972 11:24p</u> M.		
6. SEX <u>male</u>			7. RACE <u>negro</u>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>807</u>		
9. DATE OF BIRTH <u>10-4-23</u>			10. AGE (In years, lost birthday) <u>48</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>			12. CITIZEN OF <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas Woodward</u>			14. STREET AND NUMBER <u>1539 N. Bond St.</u> <u>21213</u>		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker Beth. Steel</u>			15. MOTHER'S MAIDEN NAME <u>Lela Vanfield</u>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>Yes W.W.I.</u>			17. SOCIAL SECURITY NO. <u>247-22-0595</u>		
18. INFORMANT <u>ROSANNA V. Woodward</u>			ADDRESS <u>1539 N. Bond St.</u>		
19. <u>430.91</u>			CAUSE OF DEATH <u>Ruptured berry aneurysm, circle of Willis</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C)		
20A. DATE OF OPERATION <u>2</u>			20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21. AUTOPSY? (Yes or No) <u>HEAD</u>					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22F. HOW DID INJURY OCCUR?		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Peter Lipkovic</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Peter Lipkovic, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>9-8-72</u>		
24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>			24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1972</u>			25B. NAME OF REGISTRAR <u>Arbutus</u>		
25C. FUNERAL DIRECTOR <u>ELLiott Funeral Home</u>			ADDRESS <u>1129 N. Caroline St.</u>		

35 USE

James

James

10-4-23  
J. J. A. (James Woodard)  
at this time  
J. J. A. (James Woodard)  
at this time

James

James Woodard  
at this time

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES FOSTER

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐Month Day Year  
September 2, 1972Hour  
6:00 A.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

3. DATE  
PRONOUNCED DEADMonth Day Year  
September 2, 1972Hour  
6:00 A.

5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission)

A. STATE  
Maryland

B. COUNTY

808

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1-12-38

10. AGE (In years  
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1226 N. Washington Street

11. BIRTHPLACE (State or foreign country)

S. Carolina

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

James Foster

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist Operator

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Josephine Mc Donnell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

215-56-4522

18. INFORMANT

ADDRESS

Audrey C. Foster 1315 N. Milton Ave

19.

E859.10

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Xylocaine overdose administered for  
treatment of PVC's

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Hospital

22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?

Johns Hopkins Hospital

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

9-2-72

Unkn. m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Therapeutic misadventure

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

ASSOCIATE MEDICAL EXAMINER ☐

September 3, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

9-7-72

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Winnsboro S.C.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 6 1972

Audrey C. Foster

El Goff Funeral Home 1129 N. Carolina

11-29-1972 - Completion of cause of death on a pending medical examiner death certificate-  
Peter Lipkovic, M.D. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-362		72 08533		BALTIMORE CITY HEALTH DEPARTMENT		72 08533	
BIRTH NO.				REG. NO. [REDACTED]			
1. NAME OF DECEASED (Type or Print) <u>Strachecker - Benjamin</u>				2. DATE AND HOUR OF DEATH <u>Aug 29 - 1972 12:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>604</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Home</u> <u>1400 John Dr</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1214 Zolaw Place</u>			
5. SEX <u>m</u>	6. RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-87</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <u>Unkenn</u>		11. BIRTHPLACE (State or foreign country) <u>Unkenn</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME				
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <u>219-01-3914</u>			17. INFORMANT ADDRESS				
18. <u>412.31</u> CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>asthma long disease</u> years DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>leprosy credit thrombosis with</u> months DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>asthma long disease</u> years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> 19 <u>72</u> to <u>8/29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/29</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>8/30/72</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. H. MACHAT MD</u>				23D. ADDRESS <u>212 Red St Baltimore 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>Sept 2 '72</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH OFF. <u>SEP 6 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Witzke 1630</u>		ADDRESS <u>Edmondson Ave Catonsville Md</u>	

7/14/72

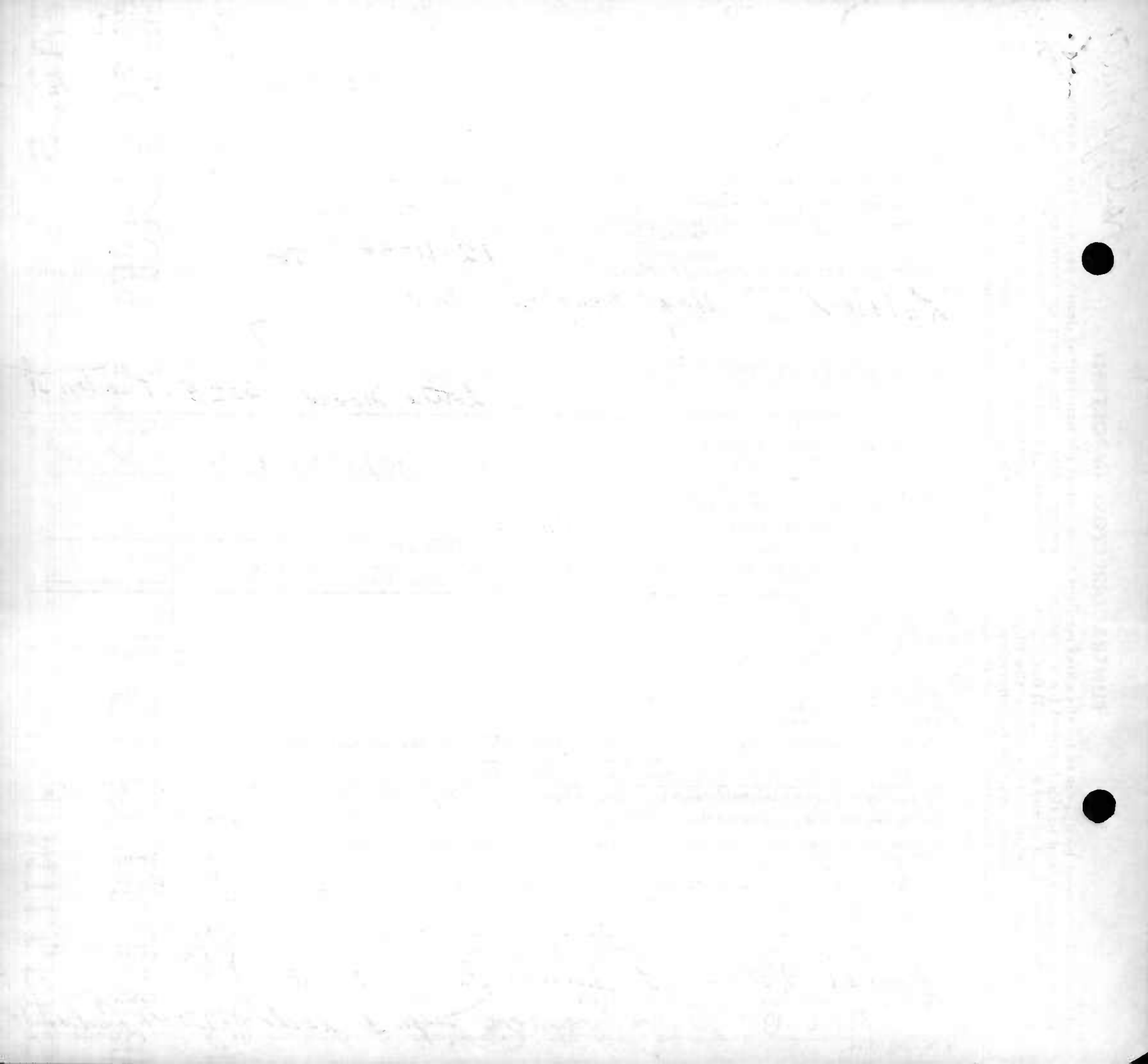
101 N. Broadway



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such writer: approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08534	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DHMH	
RO JAMES ROSS		9/5/72 15 <sup>15</sup> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		B. COUNTY	
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		902 E. PRESTON STREET			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
MALE	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-11-96	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Attendant Promotional		MD	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		220-22-0620		Lottie Moore 902 E. Preston St	
18. 599.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		30 min	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cardio respiratory arrest			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Uremia			
		(C) Chronic urinary tract infection			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from September 1 1972 to September 5 1972 that (I) (we) last saw the deceased alive on September 5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Douglas J. Deutsch M.D.		9-5-72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DOUGLAS J. DEUTSCH M.D.		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		9/8/72		Mt. Auburn Cem.	
24D. LOCATION (City, town, or county)		24E. STATE			
Baltimore		MD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 6 1972		Lillian Hinton		Joseph J. Lock 1304 N. Central Ave	



W-200

72 08535 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FREDERICK WISE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MERCY HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 4, 1972 10:10 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Oct. 1, 1931</b>		10. AGE (In years last birthday) <b>40</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Cutter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Levenson Shoe Co.</b>	
15. MOTHER'S MAIDEN NAME <b>Anna Jubb</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Korean Conflict</b>	
17. SOCIAL SECURITY NO. <b>215-28-5857</b>		18. INFORMANT <b>Anna Wise</b>	
19. CAUSE OF DEATH <b>E 953X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hanging</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Antecedent Causes</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Utility room</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Balto. City Jail</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>9-4-72 8:30 A.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Hanged himself</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-7-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Carmel Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>5712 O'Donnell St. Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Boston</b>	
25C. FUNERAL DIRECTOR <b>Charles S. Geiler</b>		ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>	

CHANDLER, J. L.

X

X

W. L.

Oct. 1, 1911

2

Letter to Mr. J. L. Chandler

Dear Mr. Chandler:

Yes

Very truly yours,

W. L. Chandler, Jr.

W. L. Chandler, Jr.

W. L. Chandler, Jr.

W. L. Chandler, Jr.

W. L. Chandler, Jr.

W. L. Chandler, Jr.

W. L. Chandler, Jr.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

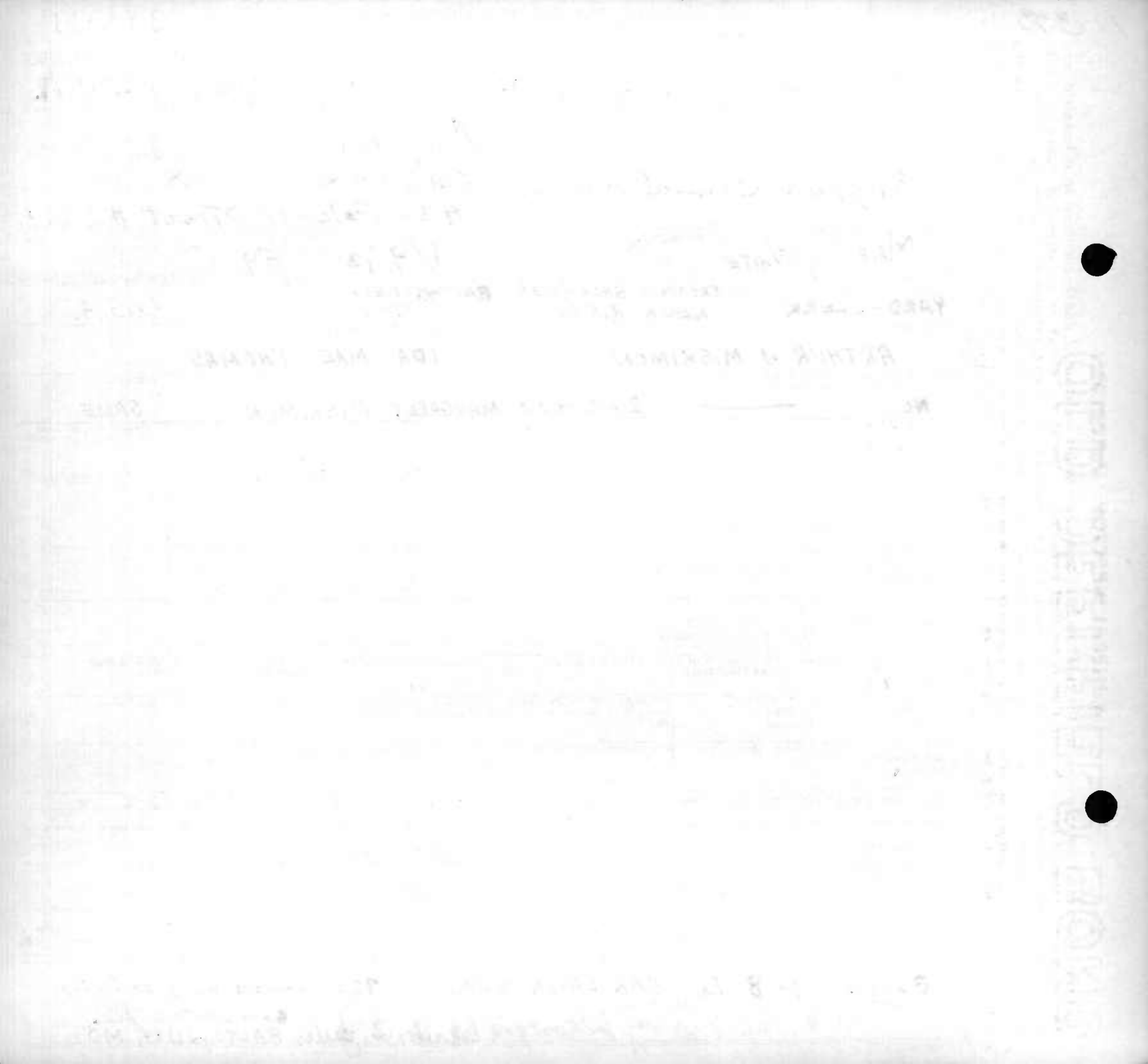
M-255

72 08536

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

72 08536

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Lester P. Miskimon, Sr.</b>		2. DATE AND HOUR OF DEATH <b>9/5/72 12:55 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2605</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1/9/13</b>		9. AGE (in years last birthday) <b>59</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>YARD - CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PATAPSCO, BACK RIVER NECK, R.R.CO.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. FATHER'S NAME <b>ARTHUR J. MISKIMON</b>		13. MOTHER'S MAIDEN NAME <b>IDA MAE THOMAS</b>		14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
15. SOCIAL SECURITY NO. <b>216-05-4153</b>		16. INFORMANT <b>MARGARET MISKIMON</b>		ADDRESS <b>SAME</b>	
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Squamous cell carcinoma of pharynx</b> (IMMEDIATE CAUSE) DUE TO, OR AS A CONSEQUENCE OF: <b>metastatic to lung</b>		18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/30/72</b> 19 to <b>9/5/72</b> 19 that (I) (we) last saw the deceased alive on <b>9/4/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Karen S. Fountain MD</b>		23B. DATE SIGNED <b>9/5/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Karen S. Fountain MD</b>	
23D. ADDRESS <b>910 Belgian Avenue, Baltimore, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-8-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>7225 EASTERN BLVD, BA.CO., MD.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 6 1972</b>	
25B. NAME OF REGISTRAR <b>Andrey K. Kostov</b>		25C. FUNERAL DIRECTOR <b>Charles J. Giller</b>		ADDRESS <b>8224 EASTERN AVE. BALTO., MD.</b>	

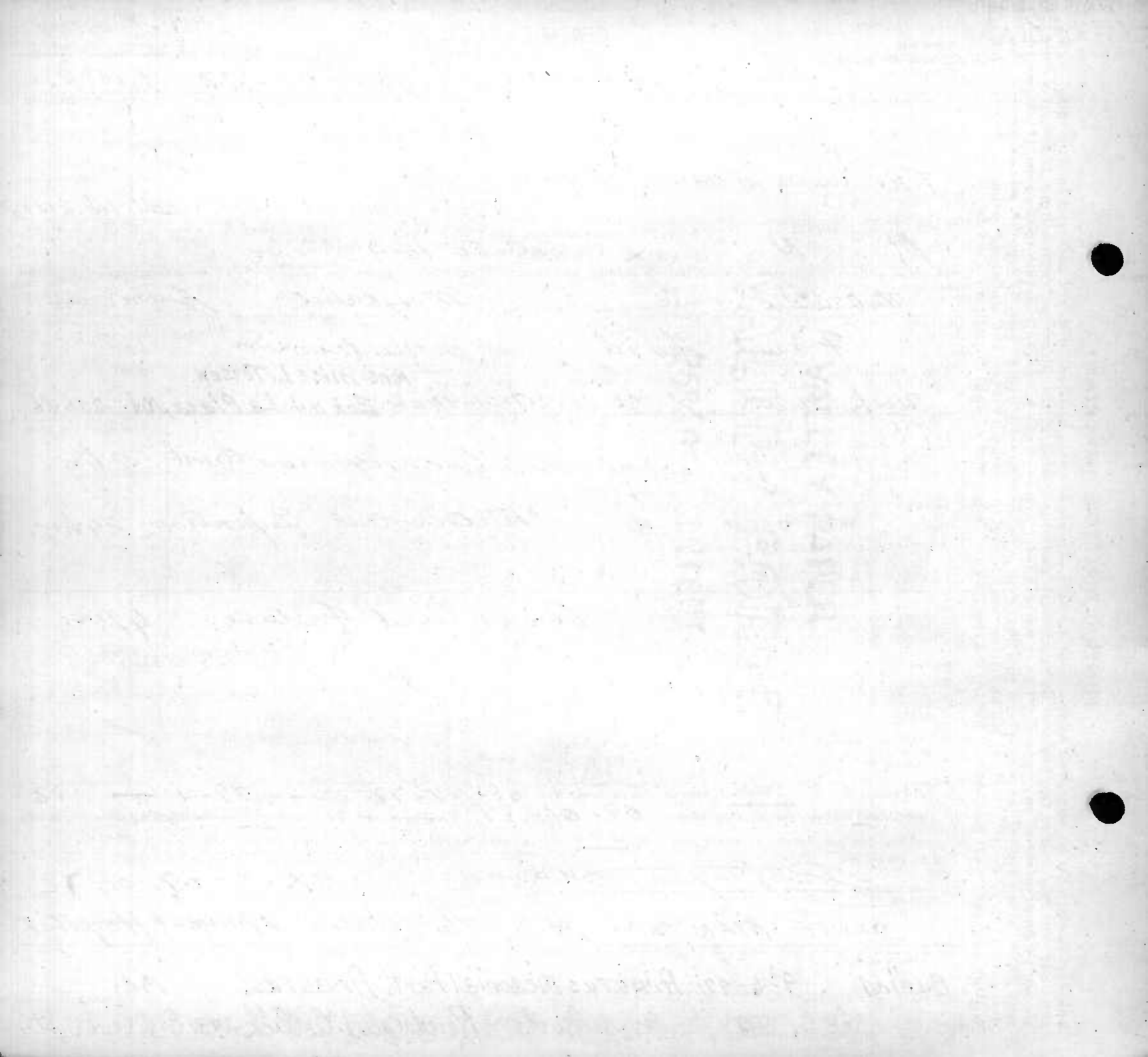


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				STATE OF MARYLAND - DHMH			
HENRY, G. LLOYD				09-01-72				9.00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY							
The Union Memorial Hospital				Maryland				908			
				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER							
				2004 Homewood Ave. Balt. Md. 21218							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. CITIZEN OF WHAT COUNTRY?	
M.		N.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		06-16-92		80		American	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Unknown								Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Frank Lloyd				Unknown							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
Unknown				BC-BS-217-01-4406				Mrs. Alice L. Tolson			
								ADDRESS			
								Box 164 La Plata, Md. 20646			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Cardiorespiratory Arrest 26 hrs.			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:				Myocardial Infarction 24 hrs.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:							
II				Chronic Renal Failure.				47 years.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				Yes							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 08-02-72 19 to 09-01-1972, that (I) (we) lost saw the deceased alive on 09-01-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Dante Manjari, M.D.								09-01-72			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
DANTE MANJARI, M.D.								The Union Memorial Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		9-6-72		Arbutus Memorial Park Arbutus, Md.							
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
SEP 6 1972		A. J. J. J. J. J.		Randolph J. Collick		2431 E. Oliver St.					



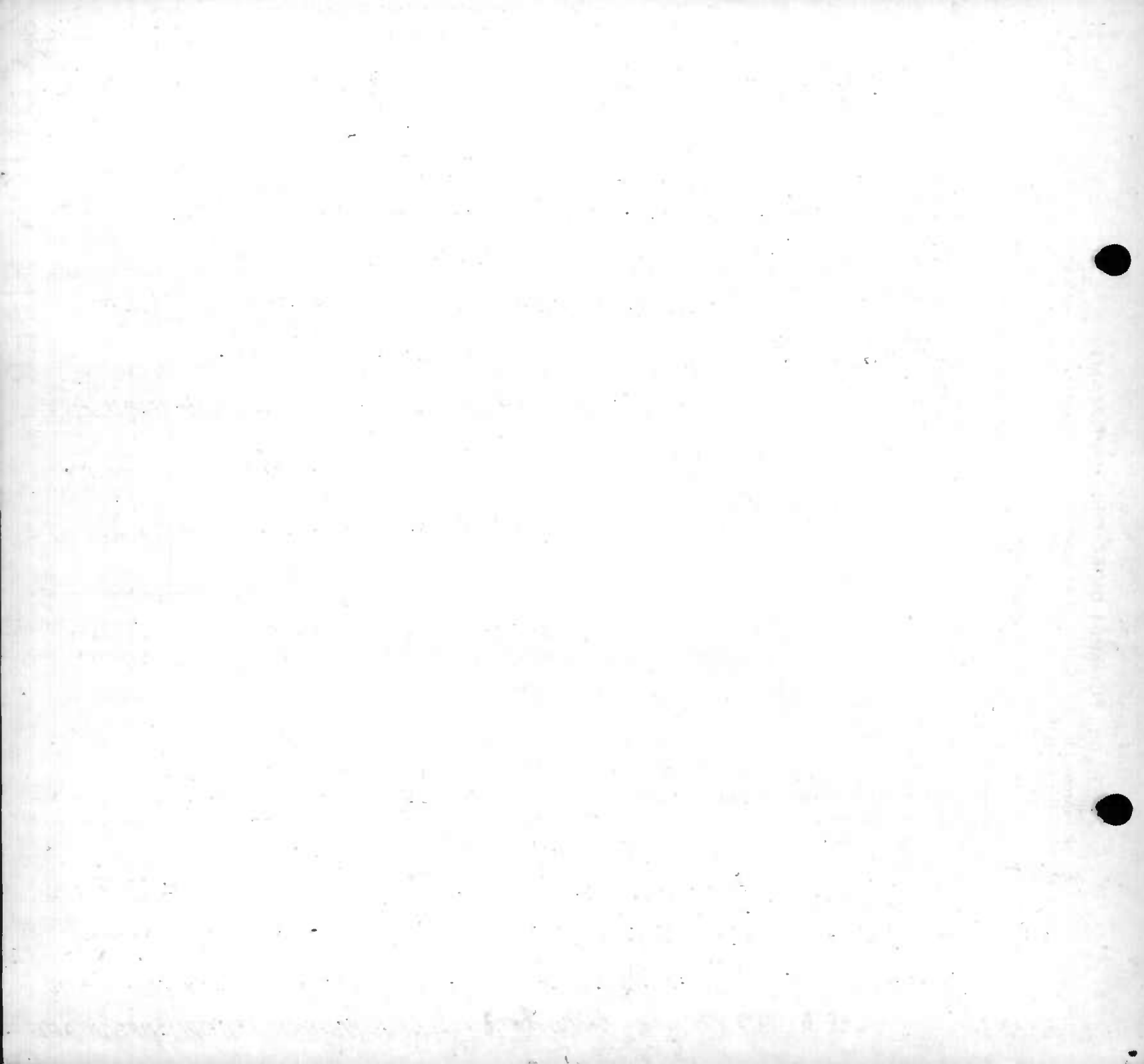




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		72 (8538) CERTIFICATE OF DEATH		REG. NO.		72 08538	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Steiner, Charles G.				9/4/72 6:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
CATON Manor Nursing Center				MARYLAND 2553			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2/24/1898	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		BALTO. TRANSIT CO.		PENNSYLVANIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ISAAC Steiner				LAURA Miller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				213-10-1109		AWALTER STEINER 2152 HARMAN AVE	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Coronary failure 2 hrs			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Atherosclerosis CVD 1 hr			
II				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Green cremated 2 yrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9/2/72 1972 to 9/4/72 1972, that (I) (we) last saw the deceased alive on 9/4/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Cliff Ratliff, Jr. DEGREE				9/5/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CLIFF RATLIFF, JR. DEGREE				5772 W. 11th Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9-8-72		LORRAINE PARK CEM		BALTO. COUNTY MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 6 1972		Sidney W. Weber		WEBER FUNERAL HOME 5311 EDMONDSON AVE			



N-362

72 08539 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DHMH

REG. NO. 72 08539

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James Nadrowski

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month  
8Day  
31Year  
72Hour  
6:45 P.M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

3. DATE  
PRONOUNCED DEADMonth  
8Day  
31Year  
72Hour  
6:45 P.M.5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)  
A. STATE B. COUNTY

Maryland

2642

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

AUG-31-1903

10. AGE (In years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

4303 Nicholas Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME

Adam Nadrowski (Deceased)

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Sp. Pt.

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

213-09-0832

18. INFORMANT

Frances Nadrowski 4303 Nicholas Avenue

19. 412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-1-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-5-72

24C. NAME OF CEMETERY or CREMATORY

Holy Rosary Cemetery

24D. LOCATION (City, town, or county) (State)

Dundalk, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 6 1972

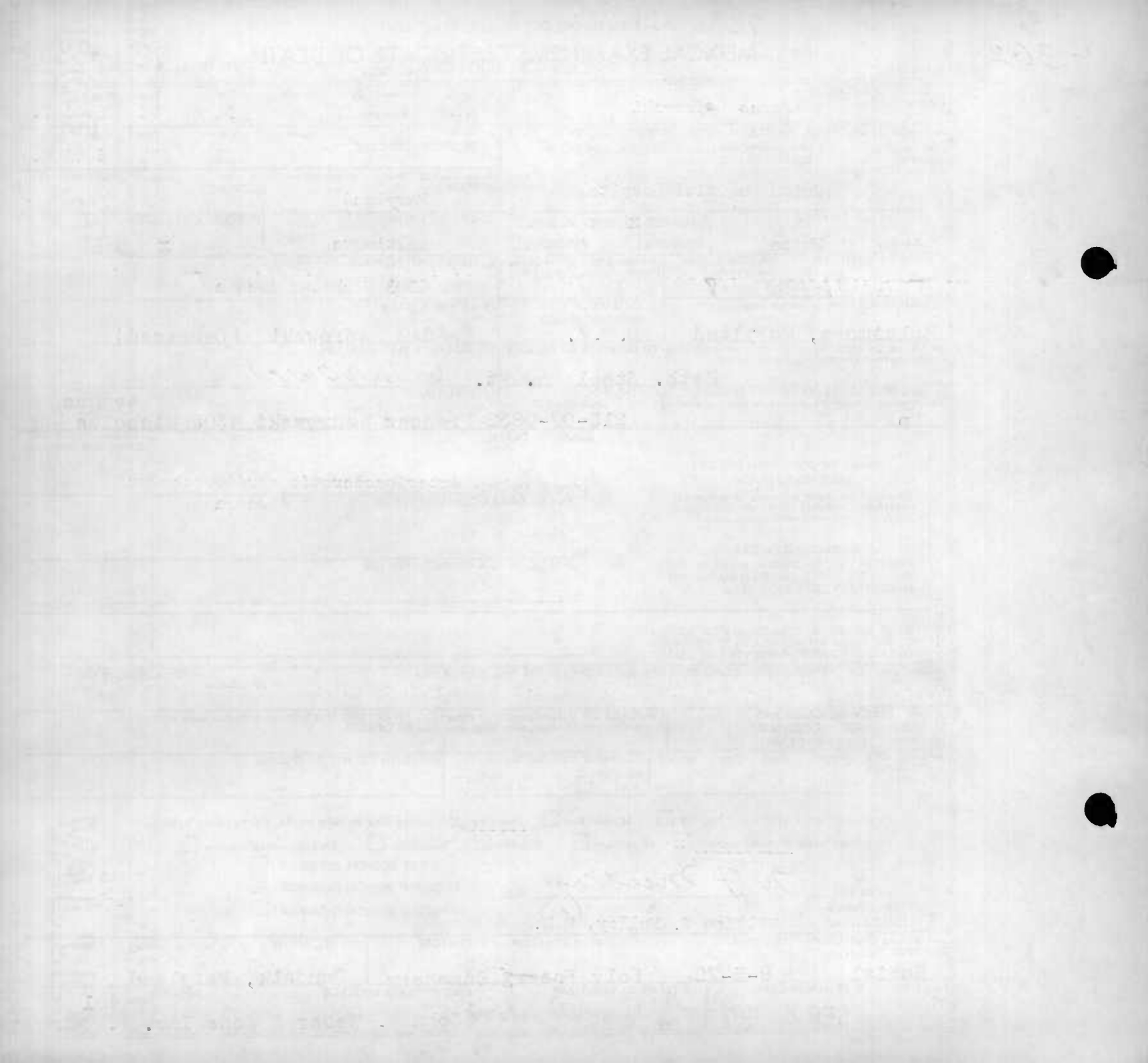
25B. NAME OF REGISTRAR

Sidney J. Boston

25C. FUNERAL DIRECTOR

John M. Weber &amp; Sons Inc. S. Chester

ADDRESS 401



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

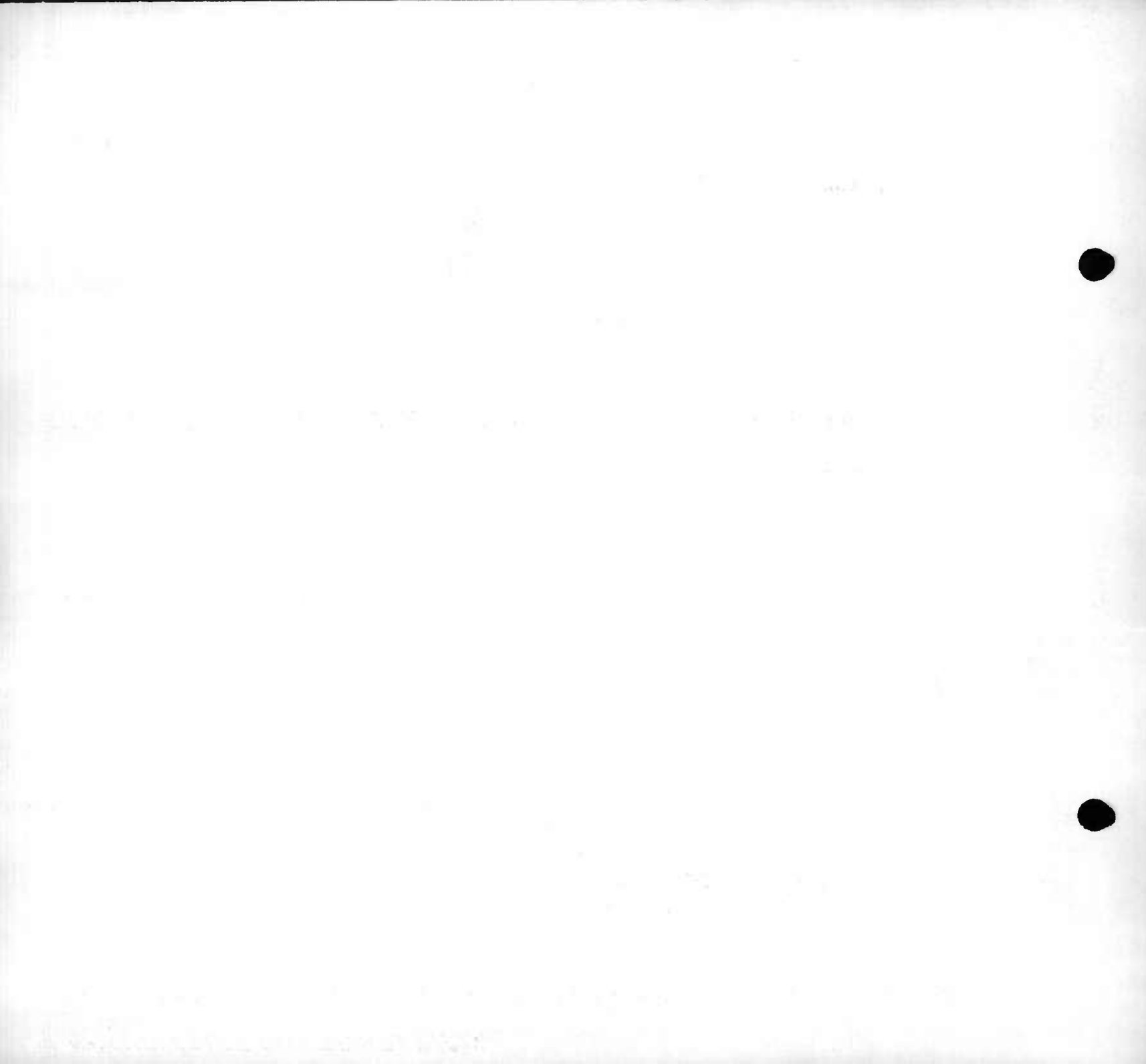
M-2201

72 08540

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 72 08540  
STATE OF MARYLAND-DHM

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM J MACZIS</b>		2. DATE AND HOUR OF DEATH <b>2 SEPT 1972 8:55 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSPITAL</b> <b>38</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4405 HOOPER AVE</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-6-06</b>	9. AGE (In years last birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>REARS DRUG CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM J MACZIS</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN TRACY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 11/6/42-12/23/45</b>		16. SOCIAL SECURITY NO. <b>214-01-1266</b>		17. INFORMANT <b>ROSE MACZIS 4405 HOOPER AVE</b>	
18. <b>203X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIOPULMONARY ARREST</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <b>MULTIPLE MYELOMA</b>		<b>5 MONTHS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>8/5/83</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MULTIPLE MYELOMA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/9/72</b> to <b>9/2/72</b> that (I) (we) last saw the deceased alive on <b>2 SEPT 19 72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John Wolfe Blotter MD</b>				23B. DATE SIGNED <b>9/2/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN WOLFE BLOTTER</b>		23D. ADDRESS <b>22 S GREENE ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-6-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MEADOW RIDGE CEM.</b>	
24D. LOCATION <b>BALTO. COUNTY MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Adrian L. Horton</b>		25C. FUNERAL DIRECTOR <b>WEBER FUNERAL HOME 5311 EDMONDSON AVE.</b>	



72 08541

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO.

72 08541

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SAMUEL W. TRACY

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

September 4, 1972

8:10 A.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY BALTO.

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

8-24-23

10. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

6 Edmondson Ridge Road

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

HENRY TRACY

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PAINTER

14B. KIND OF BUSINESS OR INDUSTRY

MELVIN HOME IMP. CO.

15. MOTHER'S MAIDEN NAME

GRACE MCKENZIE

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

KOREAN

17. SOCIAL  
SECURITY NO.

217-18-3622

18. INFORMANT

ADDRESS

VIRGINIA SAUERWALD 6 EDMONDSON RIDGE RD.

19. 571.8

CAUSE OF DEATH

Fatty metamorphosis of liver

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

9-9-72

24C. NAME of CEMETERY or CREMATORY

GOOD SHEPHERD CEM

24D. LOCATION

(City, town, or county)

(State)

HOWARD COUNTY MD.

25A. DATE REC'D BY HEALTH DEPT.

SEP 6 1972

25B. NAME OF REGISTRAR

Audrey Whitton

25C. FUNERAL DIRECTOR

ADDRESS

WEBER FUNERAL HOME 5311 EDMONDSON AVE

Page 1

Page 2

Page 3

Page 4

Page 5

Page 6

Page 7

Page 8

Page 9

Page 10

Page 11

Page 12



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPT

REG. NO.

72 08542

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) EDWARD C. ROBINSON2. DATE OF DEATH  
Known ☐ Estimated ☐ Month Day Year Hour M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)3. DATE PRONOUNCED DEAD  
Month Day Year Hour M.  
September 2, 1972 7:40 A.M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY 15476. SEX Male  
7. RACE NegroB. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN Baltimore  
D. INSIDE CITY LIMITS? YES ☐ NO ☐9. DATE OF BIRTH  
Sept. 4, 191310. AGE (In years last birthday) 58  
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.E. STREET AND NUMBER  
2323 Koko Lane11. BIRTHPLACE (State or foreign country)  
Sharon Hill, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
George W. Robinson14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Teacher14B. KIND OF BUSINESS OR INDUSTRY  
Public School15. MOTHER'S MAIDEN NAME  
Josephine Carey

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT ADDRESS  
Sarah Robinson 2323 Koko Lane19. E 958X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)CAUSE OF DEATH  
Multiple Injuries

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Street22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  
2500 Liberty Heights Ave. E. of Ocalla Street

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9-2-72 7:30 A. m.

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Dove into path of auto 1505

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/2/72

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

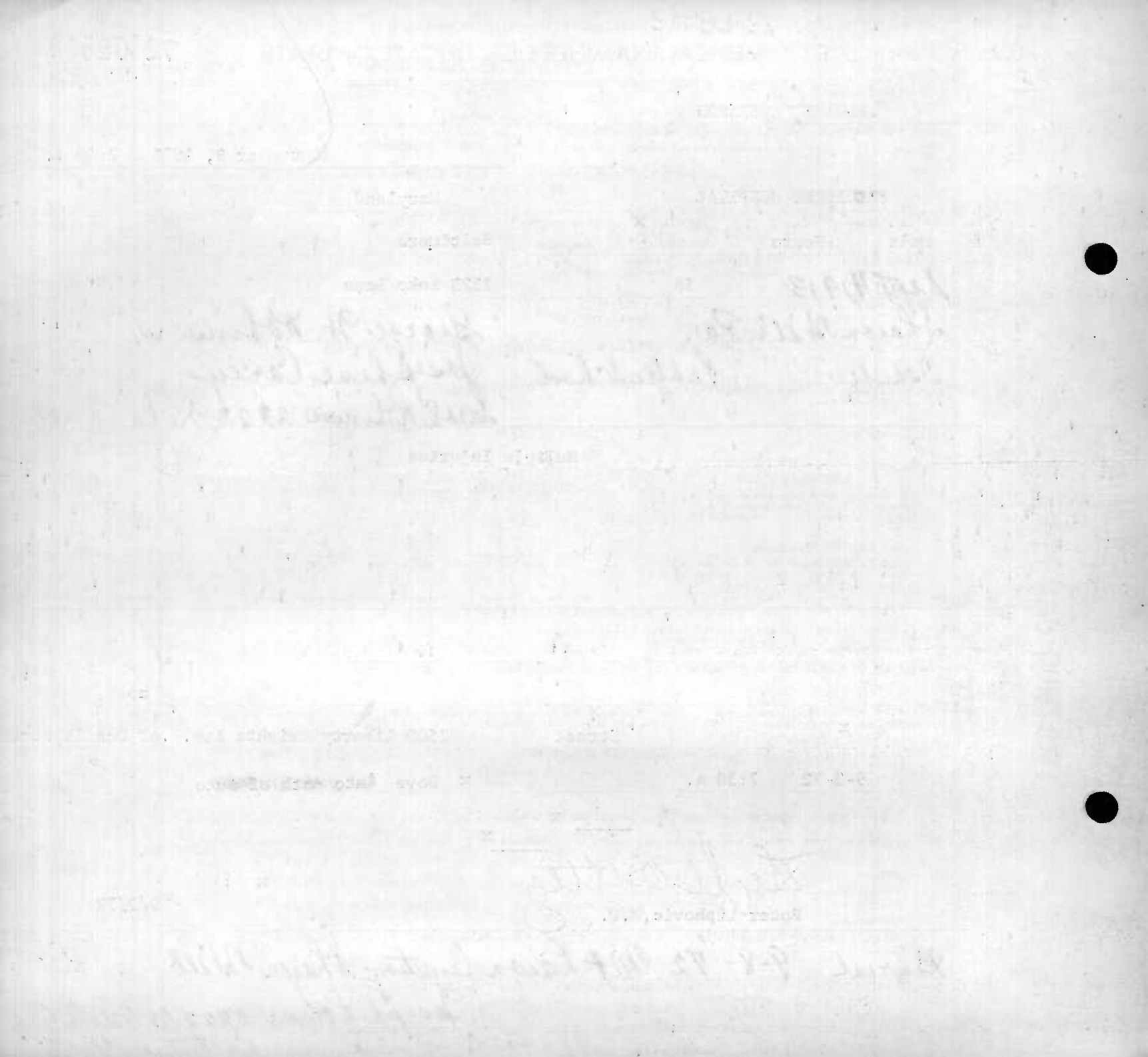
24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

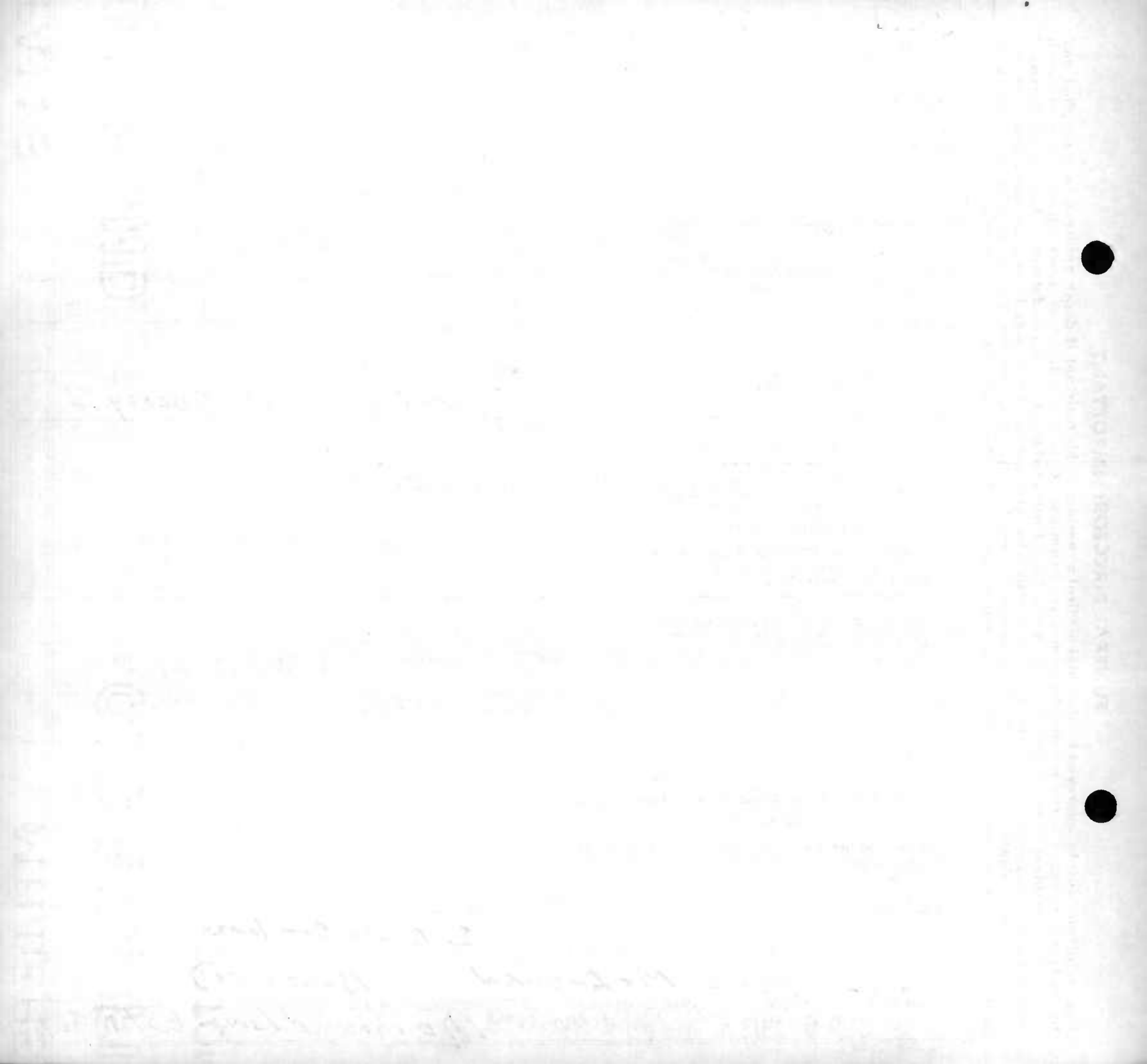
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

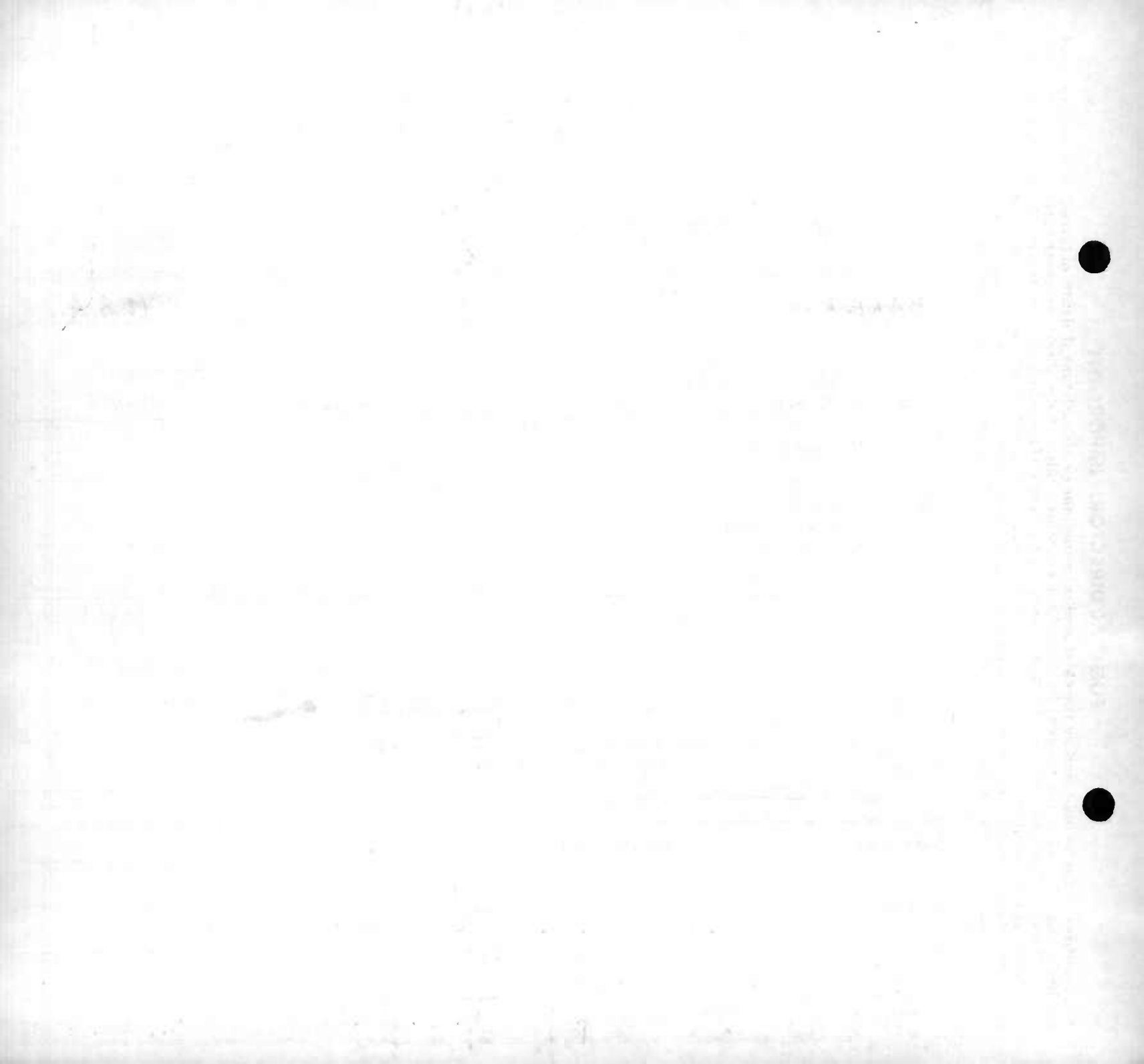
BIRTH NO. <span style="float: right;">72 08543</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 08543</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
EURA COOK				9-1-72 4:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
SOUTH BALTIMORE GEN'L HOSPITAL 43				MARYLAND BALTIMORE CITY 2543			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (in years last birthday)			
FEMALE NEGRO				6-20-1898 74			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
NONE				MARYLAND			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
MATHIAS HAMMOND				ROSETTA BROOKS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				215-32-2320-A			
17. INFORMANT				ADDRESS			
18. 707.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				1 MONTH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) INFECTED DECUBITUS ULCER			
(C)				DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CEREBRAL VASCULAR ACCIDENT			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 7 - 8 - 19 72 to SEPTEMBER 1, 19 72 that (I) (we) last saw the deceased alive on SEPTEMBER 1, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE			
Theodore H. Long M.D. DEGREE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. KARPERS M.D. DEGREE				Is Boro Can Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				9-4-72			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
Mt Auburn				BALTO MD			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
SEP 6 1972				25C. FUNERAL DIRECTOR			
25D. ADDRESS				25E. ADDRESS			
25F. ADDRESS				25G. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

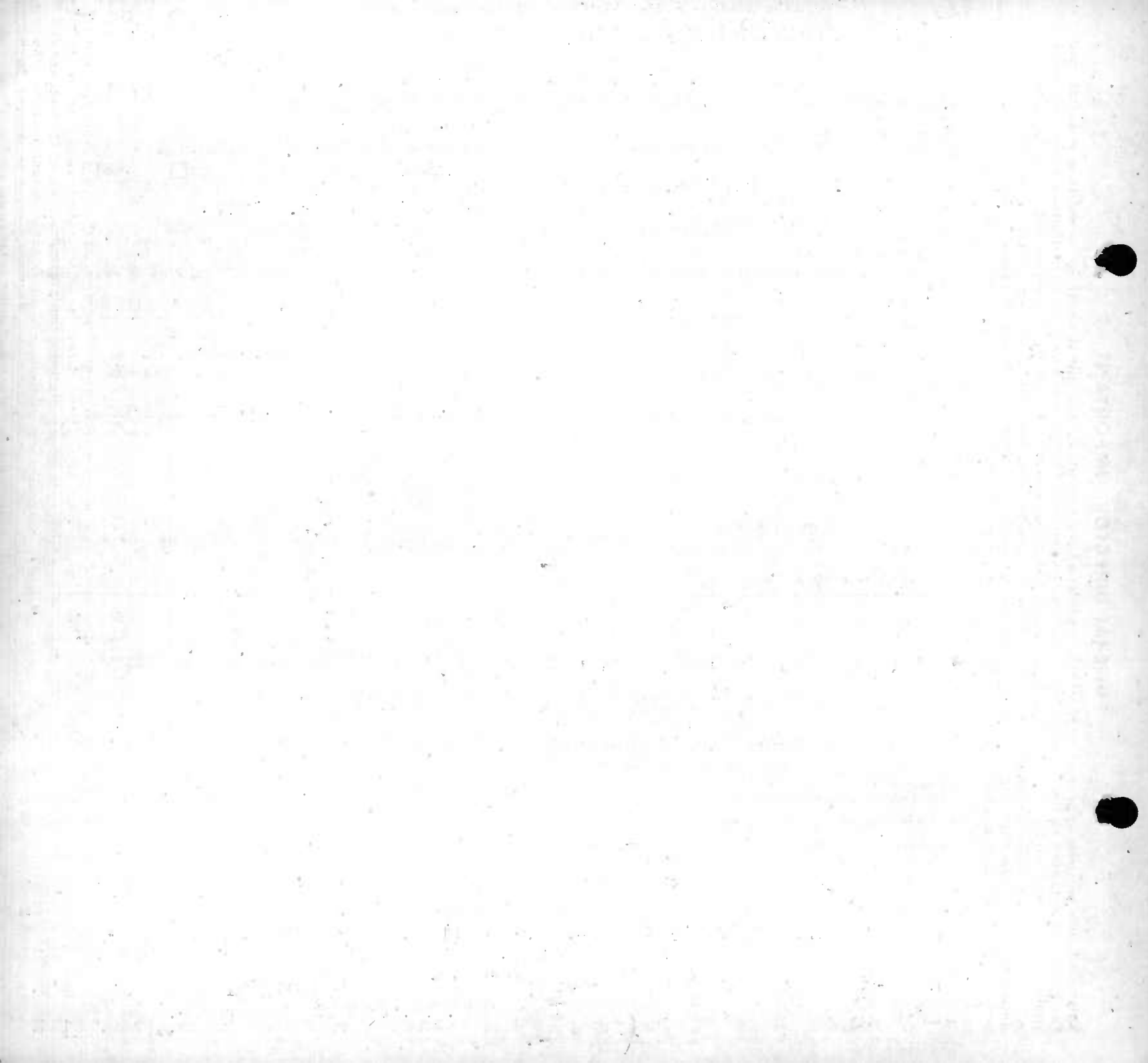
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08544</u>
72 08544				STATE OF MARYLAND - DEPT. OF HEALTH
BIRTH NO. <u>S-536</u>		1. NAME OF DECEASED (Type or Print) <u>SANDNER, Alois Sandner</u>		
2. DATE AND HOUR OF DEATH <u>9:05 PM 9/4/72</u>		M. <u>MD.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1613 WABBS NORTH WAY</u>				
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/1889</u>	9. AGE (In years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PROPRIETOR</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>		
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>214-24-5168A</u>		17. INFORMANT <u>MISS ANNA SANDNER</u> ADDRESS <u>SAME</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumococcal pneumonia</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Renal CALCULUS</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/31/72</u> to <u>9/4/72</u> that (I) (we) last saw the deceased alive on <u>9/4/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Peter H. Joyce M. D.</u> DEGREE				23B. DATE SIGNED <u>9/4/72</u>
23C. PHYSICIAN'S NAME (Type) <u>Peter H. Joyce M. D.</u> DEGREE				23D. ADDRESS <u>Union Memorial Hospital</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9-7-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	24D. LOCATION (City, town, or county) <u>Parkville</u>	(State) <u>Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1972</u>		25B. NAME OF REGISTRAR <u>Alvin J. Jenkins</u>	25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08545	
S-165 72 08545				STATE OF MARYLAND-DEMD	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lillian R. Springer		Sept. 3, 1972 17:41 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			Maryland		
00 916 Belgian Ave.			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			916 Belgian Ave. 21218		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-27-1898	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign county)		12. CITIZEN OF WHAT COUNTRY?
Housewife			New Geneva, Pa.		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Perry O'Neil			Ida Reese		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
No			Mr. Harry J. Springer		Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cerebro-Vascular Accident		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) A.S.C.V. Disease with Hypertension		
			(C).....		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 3rd 1971 to September 3rd 1972, that (I) (we) last saw the deceased alive on August 1st 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Philip D. Flynn M.D.				8 9/5/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Philip D. Flynn M.D.				11 E. Chase Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Rem-Burial		9-6-72		Oak Grove	
				24D. LOCATION (City, town, or county) (State)	
				Uniontown, Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 6 1972		H. W. Jenkins & Sons Co.		ADDRESS	
				4905 York Road Balto., Md. 21212	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

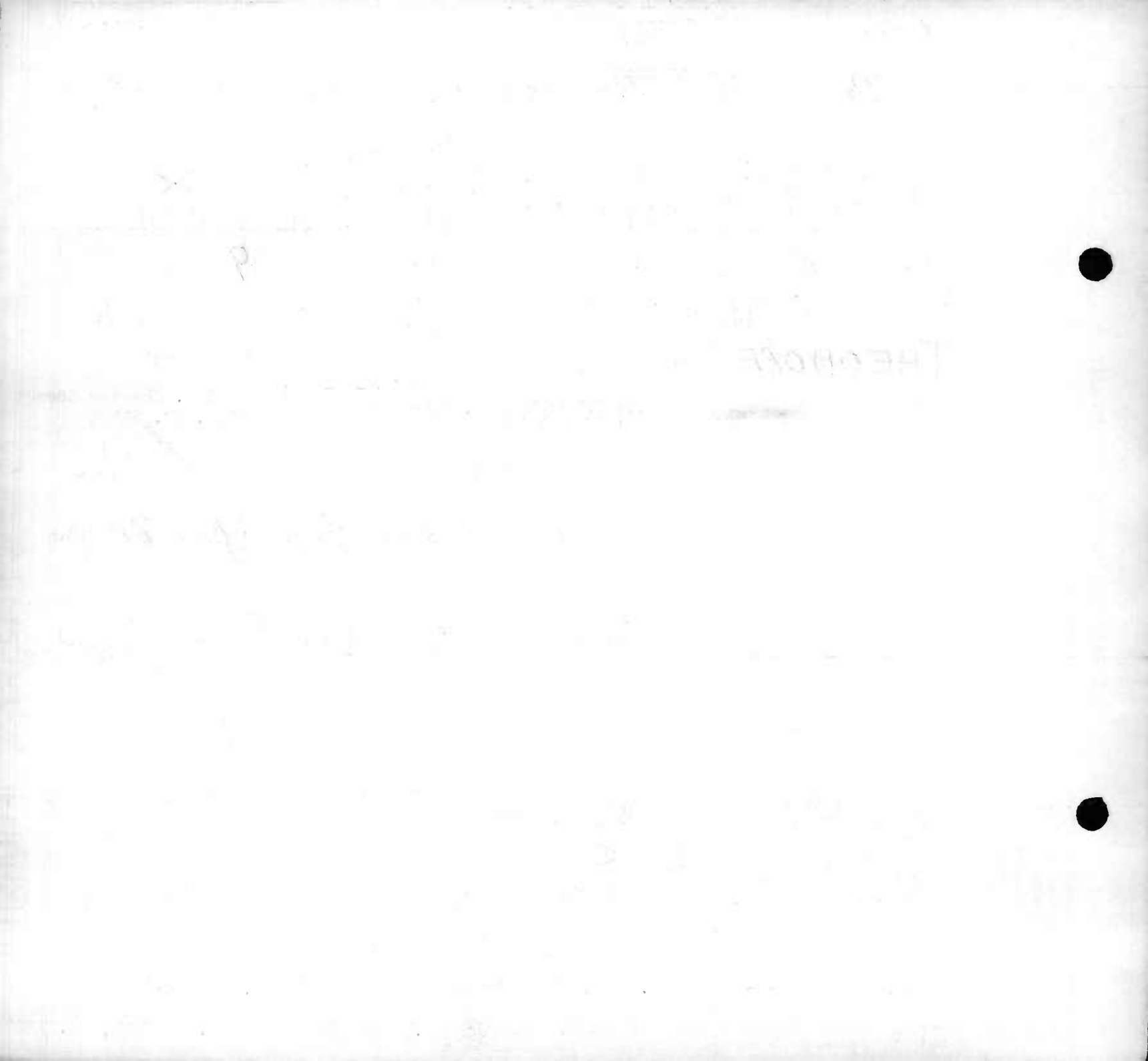
H-616		72 08546		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08546	
BIRTH NO.		72 08546		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) BENJAMIN WILSON HARPER				2. DATE AND HOUR OF DEATH Sept 4/1972 At 8 10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1206			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GENERAL HOSPITAL 9-11-72 <b>CERTIFICATE AMENDED</b>				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2443 N. CHARLES ST - 21218							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-19-09	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER - RAYMOND MAULLE C.				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN W. HARPER, Jr.				14. MOTHER'S MAIDEN NAME ANNIE B. HILBERG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. <del>1-1-1-1-1-1-1-1</del>		17. INFORMANT MRS. THOMAS E. CROW - LUTHERVILLE Md.	
18. 1541 B.S. #216-09-1699 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Terminal Cancer DUE TO, OR AS A CONSEQUENCE OF: (B) Metastatic Ca of DUE TO, OR AS A CONSEQUENCE OF: (C) Rectum			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-19 1972 to 9-4 1972 that (I) (we) last saw the deceased alive on 9/2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 8:10 pm							
23A. SIGNATURE Edward C. Yates, M.D.				23B. DATE SIGNED 9-4-72		23C. PHYSICIAN'S NAME (Type) EDUARDO C. YATCO, M.D.	
23D. ADDRESS North Charles Gen. Hosp.				23E. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-8-72		24C. NAME of CEMETERY or CREMATORY Mt. Olivet	
24D. LOCATION Balto.				24E. (City, town, or county) Md.		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972				25B. NAME OF REGISTRAR A. W. Jenkins		25C. ADDRESS 4005 York Road Balto., Md. 21212	

9-11-1972 - Correction form from Funeral Director, H.W. Jenkins & Sons Co.,  
4905 York Road, Balto., Md. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

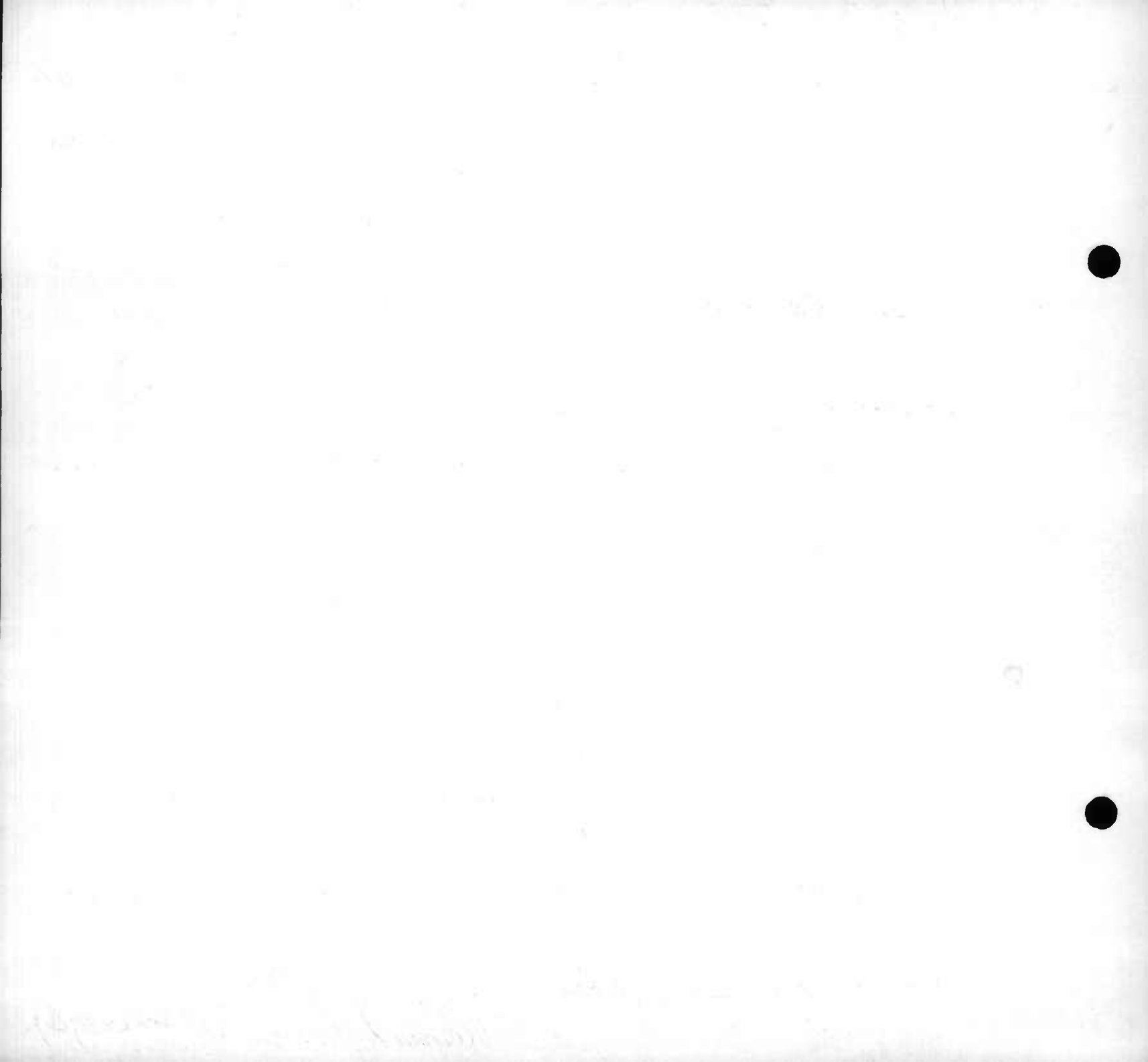
BIRTH NO. <b>M-322</b>		72 08547		BALTIMORE CITY HEALTH DEPARTMENT		72 08547	
REG. NO. <b>72 08547</b>				STATE OF <b>MARYLAND</b>			
1. NAME OF DECEASED (Type or Print) <b>Theodore Matuszak</b>				2. DATE AND HOUR OF DEATH <b>SEPTEMBER 1, 1972 8:00 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME + HOSPITAL</b>				A. STATE <b>MARYLAND</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>100 N. BROADWAY ITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>				6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/07/12</b>		9. AGE (in years last birthday) <b>59</b>		10. IF UNDER 1 Yr. Months Days		11. IF UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MARFORM OP.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Martin Marietta</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>THEODORE MATUSZAK</b>			
14. MOTHER'S MAIDEN NAME <b>WANDA Cholewczynski</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>213072513</b>				17. INFORMANT <b>Son-In-Law: Mr. John Adam</b>			
ADDRESS <b>531 S. Chester Street Balto. Md. 21224</b>				18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC HSR. Relm. Disease</b>				DUE TO, OR AS A CONSEQUENCE OF: <b>20 yrs.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>2 Previous Myocardial Infarctions</b>				DUE TO, OR AS A CONSEQUENCE OF: <b>3 yrs</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>1969</b> 19 to <b>9-1</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>9-1-72</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Theodore T. Niznik MD</b>				23B. DATE SIGNED <b>9-1-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Theo. T. NIZNIK MD</b>	
23D. ADDRESS <b>429 S. Chester St 21231</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-5-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Andrew...</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>	
ADDRESS <b>2922 Wise Ave. Dundalk, Md. 21222</b>							



FUNERAL DIRECTOR: IMPORTANT

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<p><b>P-640</b> <span style="float: right;">72 08548</span></p> <p style="text-align: right;">REG. NO. <b>72 08548</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p><b>STATE OF MARYLAND</b></p>	
<p>BIRTH NO. <b>72-11902</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>BABY GIRL PRIOLEAU</b></p>		<p>2. DATE AND HOUR OF DEATH <b>Aug 17, 72 12 50 A.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>MD</b> B. COUNTY <b>1506</b></p>		<p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>Lutheran Hosp. of Maryland</b></p>		<p>E. STREET AND NUMBER <b>1709 Poplar Grove Dr</b></p>			
<p>5. SEX <b>female</b></p>	<p>6. RACE <b>negro</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>Aug 17 72</b></p>	<p>9. AGE (In years last birthday) <b>1 day</b></p>	<p>If Under 1 Yr. Months: Days: Hours: Min. <b>50</b></p>
<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>NEVER EMPLOYED</b></p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p><b>USA</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>John Priolean</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Elizabeth Priolean</b></p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>Not Known</b></p>		<p>17. INFORMANT <b>Mother's chart</b> ADDRESS</p>	
<p>18. CAUSE OF DEATH</p>		<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>Prematurity</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>50 min</b></p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) <b>Placental insufficiency</b></p> <p>(C) <b>multiparity</b></p>		<p><b>unknown</b></p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Aug 17 19 72</b> to <b>Aug 17 19 72</b> that (I) (we) last saw the deceased alive on <b>Aug 17 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>Sang Y. Rhim, M.D.</b></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>		<p>23B. DATE SIGNED <b>8/17/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>SANG Y. RHIM, M.D.</b></p>		<p>23D. ADDRESS <b>Lutheran Hosp. of Maryland</b></p>			
<p>24A. BURIAL CREMATION REMOVAL (Specify)</p>		<p>24B. DATE <b>8-30-72</b></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <b>Liberty Cemetery</b></p>	
<p>24D. LOCATION (City, town, or county) (State)</p>		<p><b>Baltimore Md</b></p>			
<p>25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Audrey W. Norton</b></p>		<p>25C. FUNERAL DIRECTOR <b>Caplan &amp; Korman</b> ADDRESS <b>817 S. ...</b></p>	



A-416

72 08549

BALTIMORE CITY HEALTH DEPARTMENT

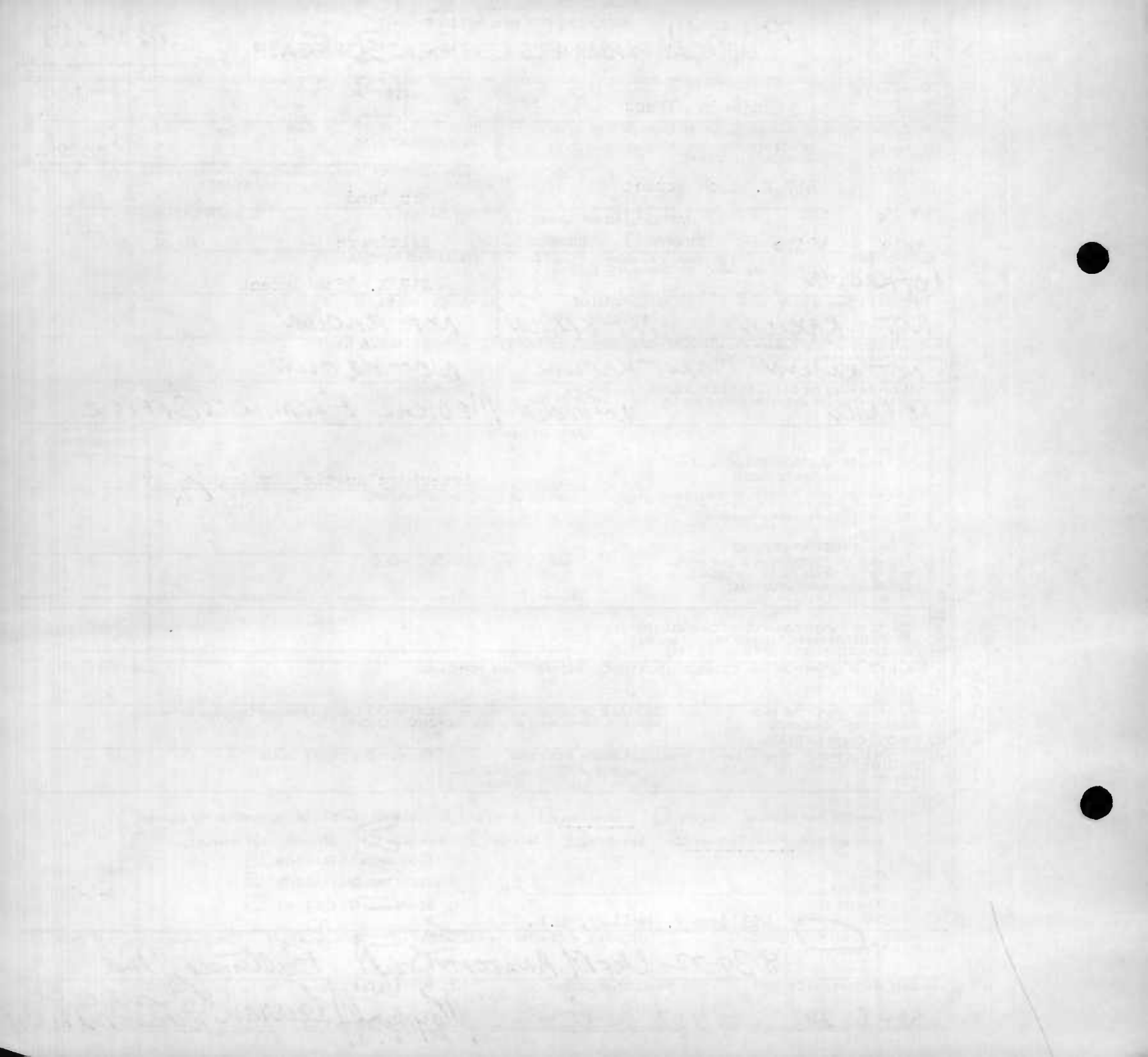
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08549

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Benjamin Albert		2. DATE OF DEATH Known <input type="checkbox"/> Found <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 4 72 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 417 E. 25th Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 4 72 10:00 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1203	
9. DATE OF BIRTH NOT KNOWN		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) NOT KNOWN		12. CITIZEN OF WHAT COUNTRY? NOT KNOWN	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOT KNOWN		14B. KIND OF BUSINESS OR INDUSTRY NOT KNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NOT KNOWN		17. SOCIAL SECURITY NO. NOT KNOWN	
18. INFORMANT ADDRESS MEDICAL EXAMINER'S OFFICE		15. MOTHER'S MAIDEN NAME NOT KNOWN	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) OF INJURY		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: W P Mulloy M.D. EXAMINER'S NAME (Type): William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 8-4-72			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 8-30-72	
24C. NAME OF CEMETERY or CREMATORY WORM ANATOMY Bldg.		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR Sidney H. Hinton	
25C. FUNERAL DIRECTOR Raymond J. Curran		ADDRESS 817 Southgate Towson Md 21204	





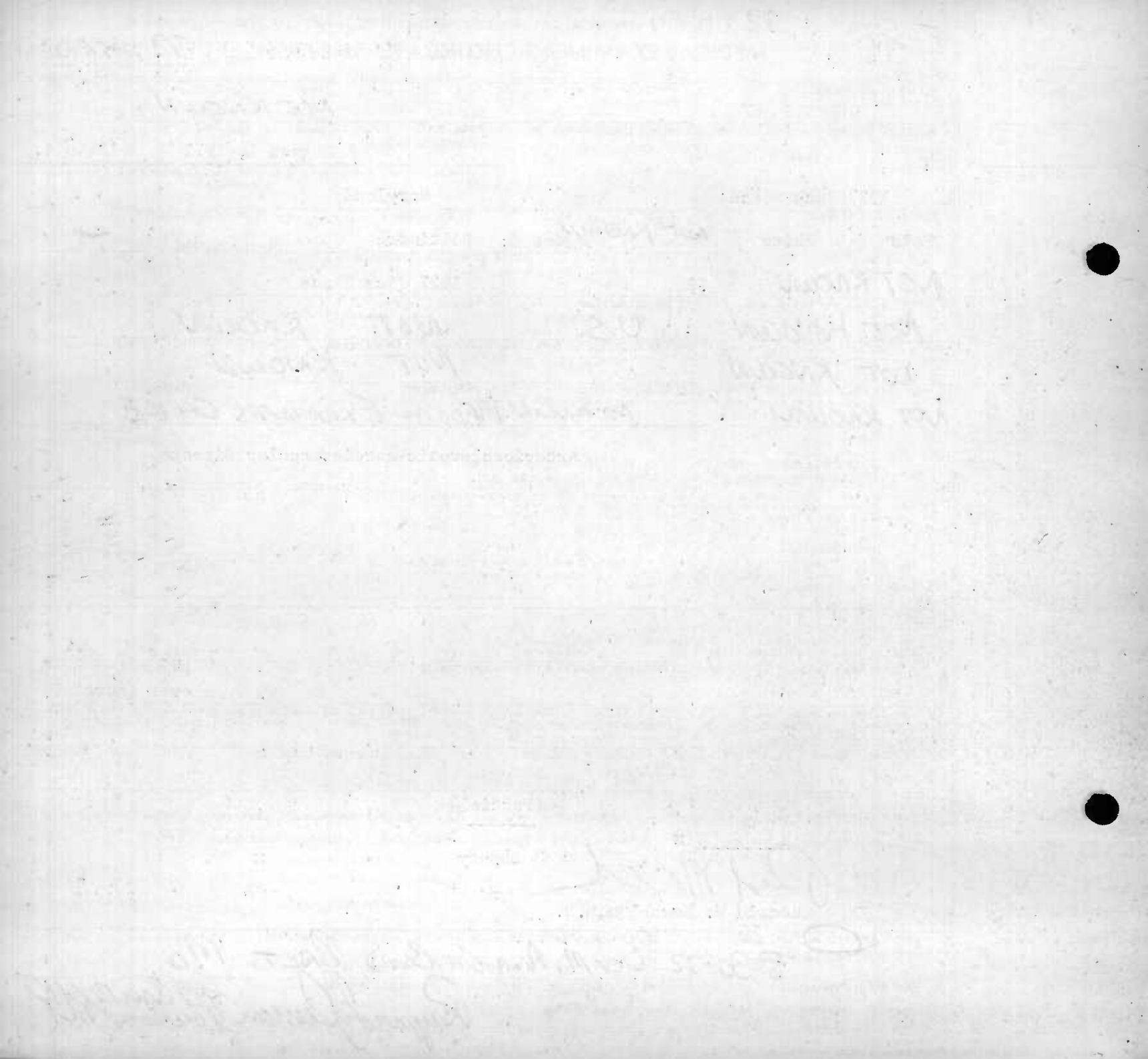
E-000

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08550

## BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES EY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>NOT KNOWN</b>		Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1027 Jack Place</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 1, 1972</b>		Hour <b>12:00 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>NOT KNOWN</b>		10. AGE (In years last birthday) <b>62</b>		11. BIRTHPLACE (State or foreign country) <b>NOT KNOWN</b>	
12. CITIZEN OF <b>U.S.</b>		13. FATHER'S NAME <b>NOT KNOWN</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT KNOWN</b>	
15. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NOT KNOWN</b>		17. SOCIAL SECURITY NO. <b>NOT KNOWN</b>	
18. INFORMANT <b>MEDICAL EXAMINERS OFFICE</b>		19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <b>8/1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes (partial)</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> <b>(Partial) Autopsy</b> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>8/1/72</b>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>8-30-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>U of M. Anatomy Board</b>	
24D. LOCATION (City, town or county) (State) <b>BALTIMORE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Ingham</b>	
25C. FUNERAL DIRECTOR <b>Raymond Pearson</b>		25D. ADDRESS <b>817 S. Charles St.</b>		25E. CITY <b>Baltimore, Md.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



72 08552 STATE OF MARYLAND BALTIMORE CITY HEALTH DEPARTMENT

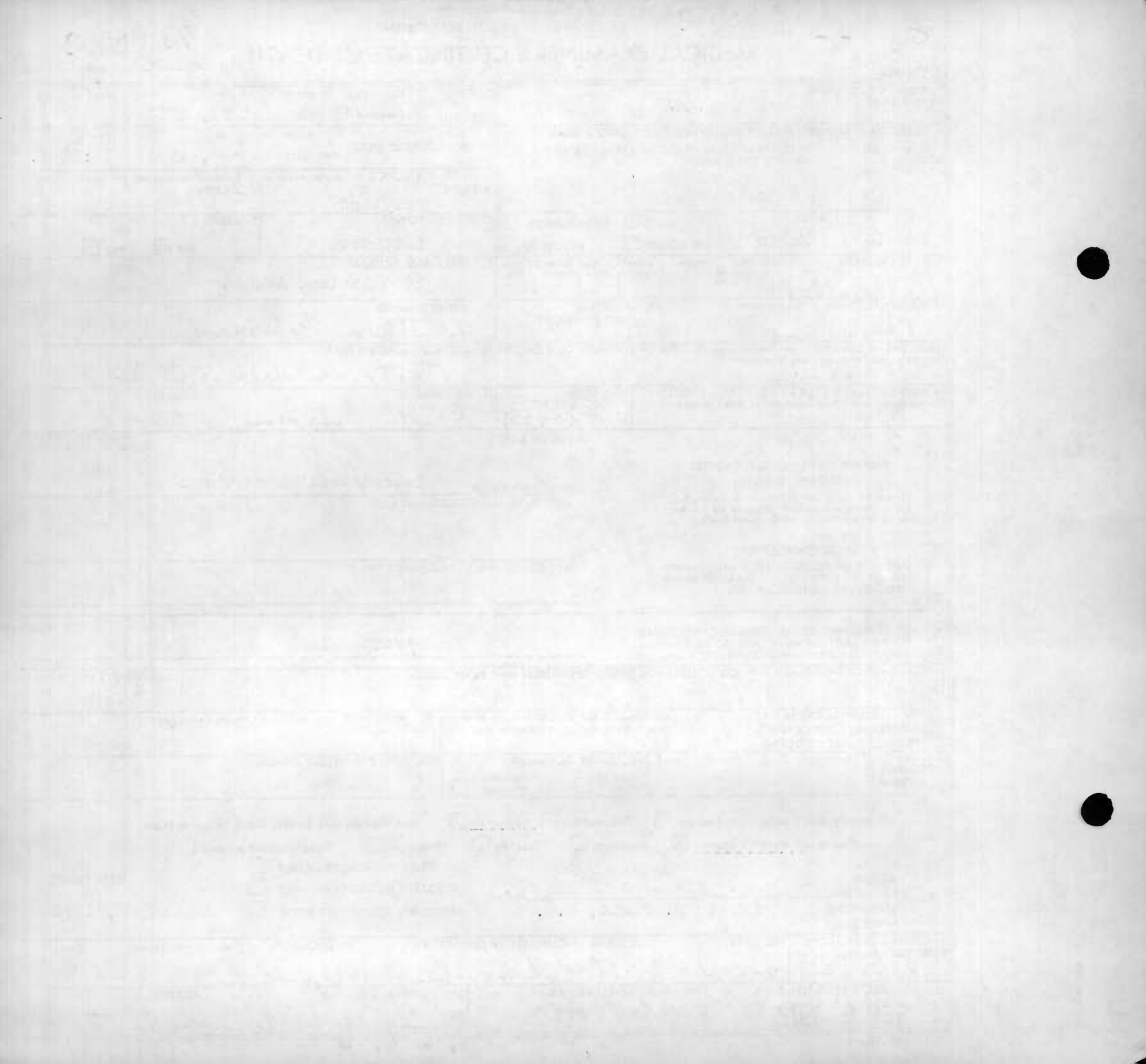
72 08552

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. S-455 REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>RUTH SOLOMON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 30, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1404 Ashland Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 30, 1972 10:50 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 15, 1929</b>		10. AGE (in years) If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. <b>42</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Solomon</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
15. MOTHER'S MAIDEN NAME <b>Beatrice Whitfield</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. SOCIAL SECURITY NO. <b>215-66-1256</b>		18. INFORMANT <b>Estell Solomon</b>	
19. CAUSE OF DEATH <b>431.0</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Intracranial hemorrhage</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertension</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hypertension</b>		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 31, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-6-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnson</b>	
25C. FUNERAL DIRECTOR <b>Chas. G. W. Lewis</b>		ADDRESS <b>1314 1st St.</b>	

VS 151-REV. 7/1/68

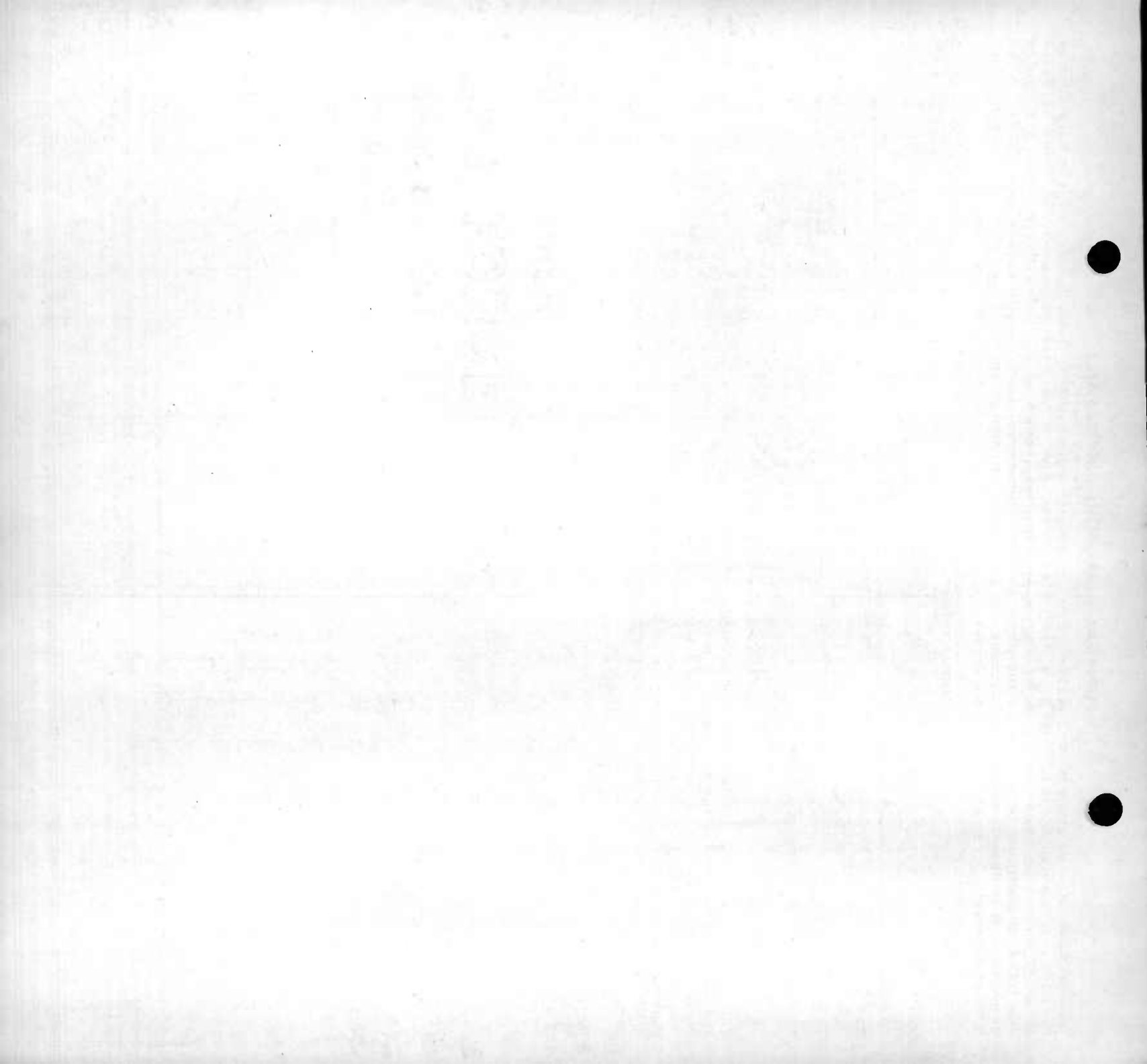


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08553	
W-362 72 08553				STATE OF MARYLAND-DEME	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Annie E. Waters		9-4-72 11:00 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE* (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
4403 Springdale Ave.				Maryland 2802	
E. STREET AND NUMBER				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4403 Springdale Ave.					
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		Colored		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife				7-18-78	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Edward Dennis Waters		Martha Tilghman		94	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		577403958D		Julia R. Woodland 4403 Springdale Ave.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				1 yr	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				Secondary Anemia Due to 1 yr	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
II				(C) Bleeding Internal uterus	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9-8 1971 to 9-4 1972, that (I) (we) last saw the deceased alive on 9-4-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
G. Franklin Phillips M.D. DEGREE				9/4/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
G. Franklin Phillips M.D. DEGREE				558 McMechan St. Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-10-72		St. James Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 6 1972		Sidney Whitford		1080 Hamilton Ave. F. H. P. Co. Md.	







This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 08554</b>	
BIRTH NO. <b>11-415</b>		STATE OF <b>MARYLAND-DEME</b>	
1. NAME OF DECEASED (Type or Print) <b>Jesse Melvin</b>		2. DATE AND HOUR OF DEATH <b>9/5/72</b> <b>6:59 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>1604</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital Inc.</b> <b>730 Ashburton St</b>		C. CITY OR TOWN <b>Balt. Md.</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>906 N. Fulton Ave.</b>	
5. SEX <b>Male</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/18</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>54</b> <sup>53</sup>
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ike Melvin</b>		14. MOTHER'S MAIDEN NAME <b>Florence</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>224-09-5933</b>	
		17. INFORMANT <b>Mr Girley Melvin, 1021 N Fulton Ave</b>	
18. <b>4709 91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>35 mts.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF	
		(B) <b>Arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>Removal of artery thrombosis over Vascular insufficiency of left leg</b>	
19A. DATE OF OPERATION <b>38-30-72</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Removal Artery Thrombosis</b>	20A. AUTOPSY (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> <b>NO</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-16-1972</b> to <b>9-5-1972</b> that (I) (we) last saw the deceased alive on <b>9-5-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Dr. Muhammad Aftab Anwar</b>		23B. DATE SIGNED <b>9-5-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. MOHAMMAD AFTAB ANWAR MD</b>		23D. ADDRESS <b>Lutheran Hospital.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/9/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>MT Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>	25B. NAME OF REGISTRAR <b>Sidney Halstead</b>	25C. FUNERAL DIRECTOR <b>Sidney Halstead</b> ADDRESS <b>1206 North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>W-300</b>		72 08555		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08555</b>	
1. NAME OF DECEASED (Type or Print) <b>CHARLES WHITE</b>				2. DATE AND HOUR OF DEATH <b>9/2/72</b> <b>8:35 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 MARYLAND GEN. HOSP. 827 LINDEN AVE. BALTO., MD. 21201</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1803</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>LINCOLN MEMORIAL NURSING HOME</b>			
5. SEX <b>MALE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/9/03</b>	9. AGE (in years last birthday) <b>69</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE CITY</b>		11. BIRTHPLACE (State or foreign country) <b>NOT KNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>				14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NOT KNOWN</b>		16. SOCIAL SECURITY NO. <b>212-14-1675</b>		17. INFORMANT <b>MURRIS HOME ADMINISTRATOR 10A POLASHUK</b>		ADDRESS <b>BARK HILL RES. HOME 1502 E. TACOMA BALTO., MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>436.91</b> <b>CAUSE OF DEATH</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Recurrent aspiration Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>about 41 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CHF</b>			
				(C) <b>Organic Brain Syndrome, CVA, ASCVD</b>		<b>stroke (?) years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>bronchial asthma</b>						<b>years (?)</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>JULY 22</b> 19 <b>72</b> to <b>SEPT. 2</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>SEPT. 2</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1)-(We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>RT MALLARI</b>				23B. DATE SIGNED <b>9/2/72</b>		23C. PHYSICIAN'S NAME (Type) <b>MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9/8/72</b>		24C. NAME of CEMETERY or CREMATORY <b>MT Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>				25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>			
25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>				25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>			
25D. ADDRESS <b>1206 W North Ave</b>							

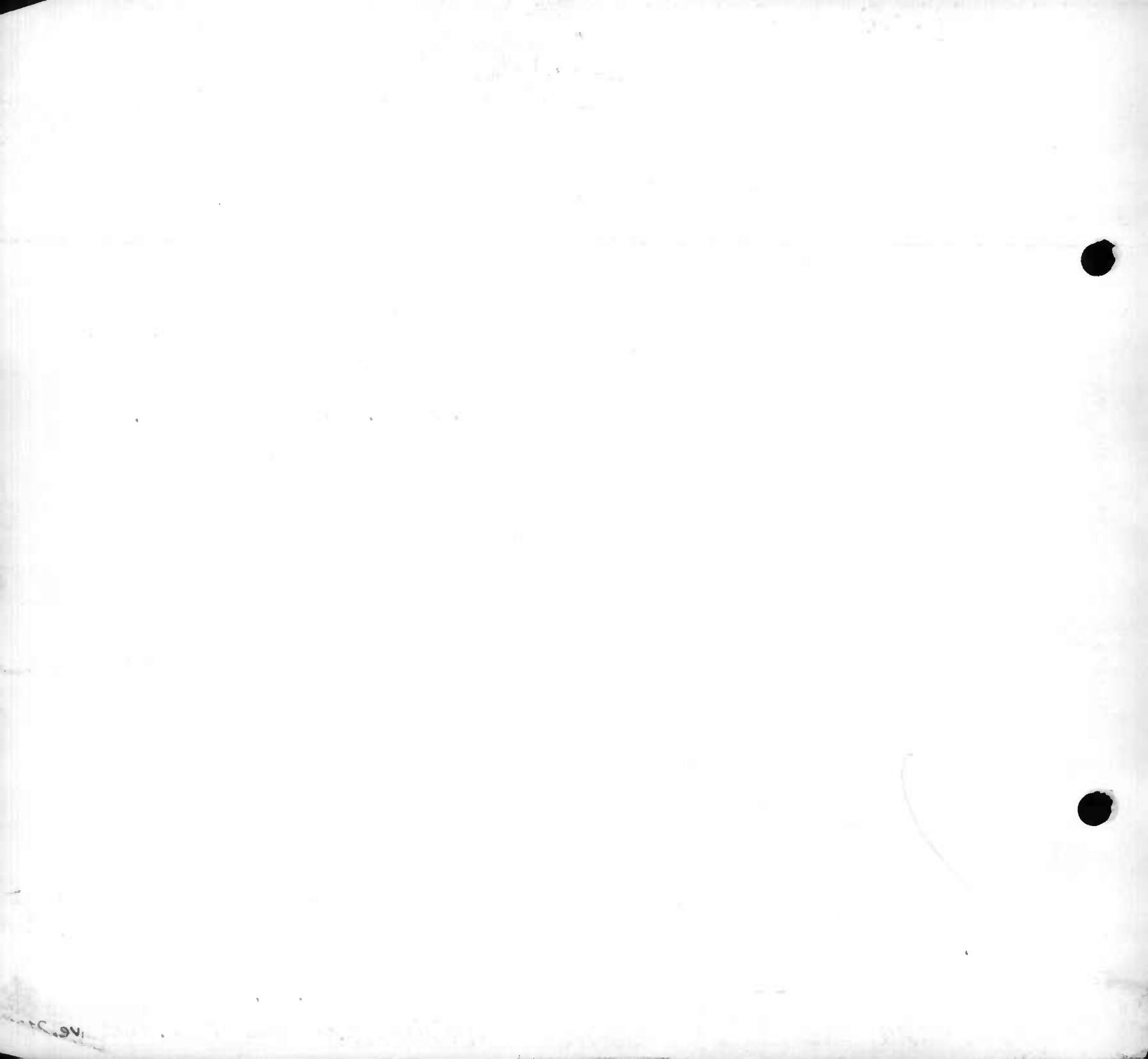
1/9/69

804 Hollins St.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

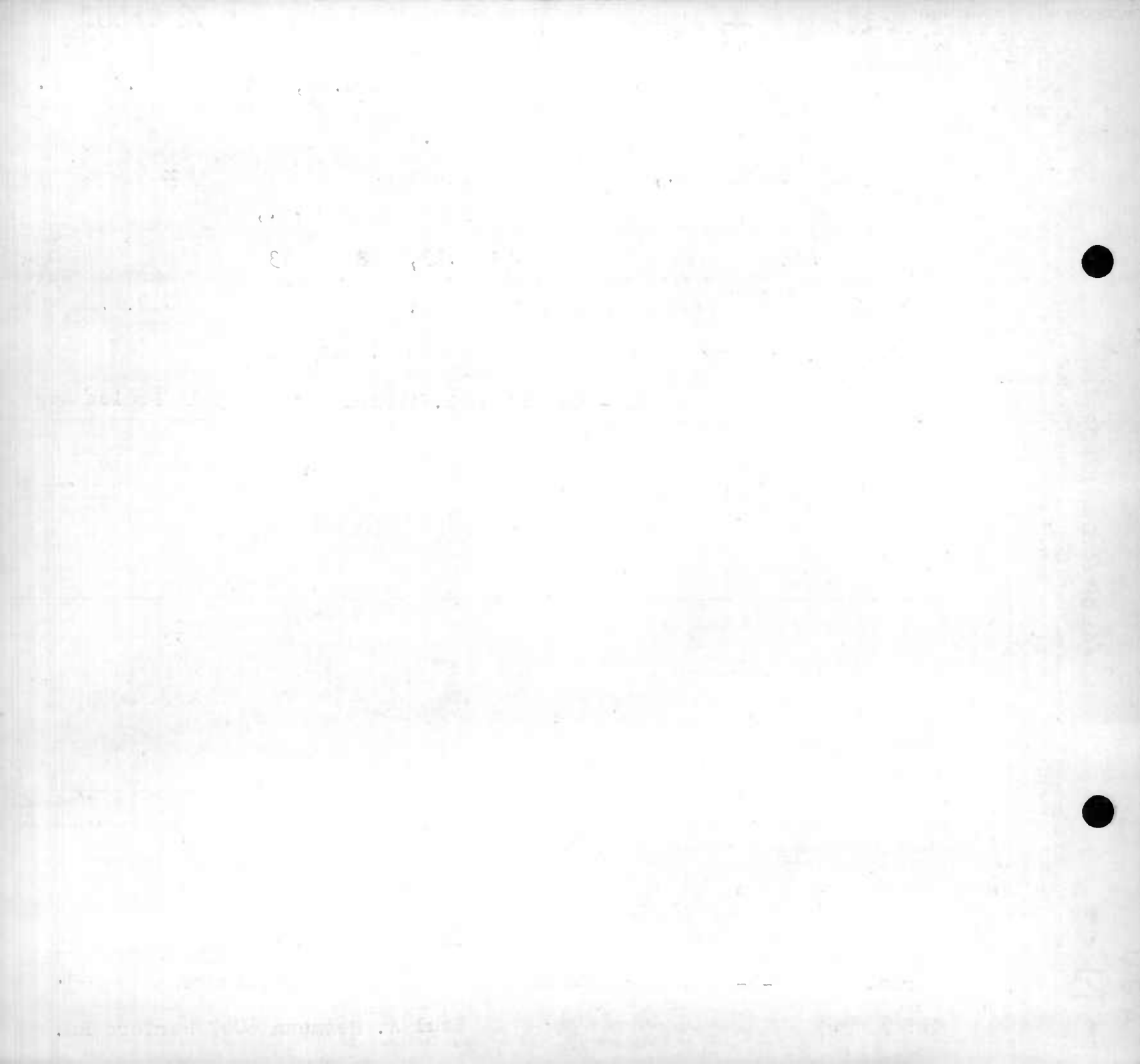
1-260 72 08556		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08556	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Agnes Lacer (Lacer)</u>		2. DATE AND HOUR OF DEATH <u>8/29/72 1451 P</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2404</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hosp.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>1736 Webster St</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/11</u>	9. AGE (in years last birthday) <u>60</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Timbs (dec)</u>		14. MOTHER'S MAIDEN NAME <u>Viola Reaney (dec)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT ADDRESS <u>Mr. Earl F. Lacer 1736 Webster St.</u>	
18. <u>27591</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest.</u> (B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 22 1972</u> to <u>7/27 1972</u> that (I) (we) last saw the deceased alive on <u>August 29 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Widely</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/29/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Cesar Hidalgo MD</u>		23D. ADDRESS <u>South Baltimore General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9-1-72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Anthony [unclear]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>McEulley Funeral Homes 130 E. Fort Ave. 21230</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08557		72 08557	
REG. NO.		STATE OF MARYLAND - PHN		72 08557	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary Elizabeth Dandy		Sept. 4, 1972 6.30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE	
00 3018 Louise Ave.,				Md.	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3018 Louise Ave.,			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	Dec. 13, 1898	73	Waitress
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Waitress		Kernan Hospital		Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Elmer C. Anthony		Maude M. Proxell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		217-01-5922		Mrs. Virginia Hanson 3018 Louise Ave	
18. 410.91		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Coronary Thrombosis	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		arteriosclerotic heart disease	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6 10 1972 to 8-28 1972, that (I) (we) lost saw the deceased alive on 8 21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
		Sebastian Russo		9/5/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		5122 Harford Road			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-6-1972		Parkwood	
24D. LOCATION (City, town, or county)		24E. STATE			
Baltimore		Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 7 1972		Bautz A. Heemann		6067 Harford Rd.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-263 72 08558		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08558	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEM	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ECKERT, JOHN MILBURN		SEPTEMBER 3, 1972		7:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND		B. COUNTY BALTIMORE	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 3008 BERO ROAD		5300	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/14/97	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City CITY GOV'T		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME PETER ECKERT		14. MOTHER'S MAIDEN NAME ANNA MARY MOXAM		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-24-6155		17. INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 03891 Circulatory Failure Septicemia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Circulatory Failure Septicemia			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from AUGUST 30 19 72 to SEPTEMBER 3 19 72, that XX (we) lost saw the deceased alive on SEPTEMBER 3 19 72 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) XXXXX view the body after death.					
23A. SIGNATURE Kuang-yen Huang		23B. DATE SIGNED 09 03 72			
23C. PHYSICIAN'S NAME (Type) KUANG-YEN HUANG M.D.		23D. ADDRESS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-6-1972		24C. NAME OF CEMETERY OR CREMATORY Crest Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Howard County, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 7 1972		25B. NAME OF REGISTRAR Sidney Hubbard	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25D. ADDRESS			

7:00

SEPT 20 1952

ST AGNES HOSPITAL

2123

BALTIMORE

MARYLAND

BALTIMORE

ST AGNES HOSPITAL

CATON & WILKINS AVENUE

3008 BEND ROAD

BALTIMORE, MARYLAND 21229

DOE LEXA

COCAINE

WALE

MARYLAND

CITY GOVT

INSPECTOR

ENCL (

RETRICK

BALTO MD 21229

NO

212-24-2122 ST AGNES RECORDS CATON & WILKINS

SEPTEMBER 20 1952

AUGUST 30 1952

SEPTEMBER 3 1952

XXXXX

09 03 72

AVENUE, BALTO, MD 21229

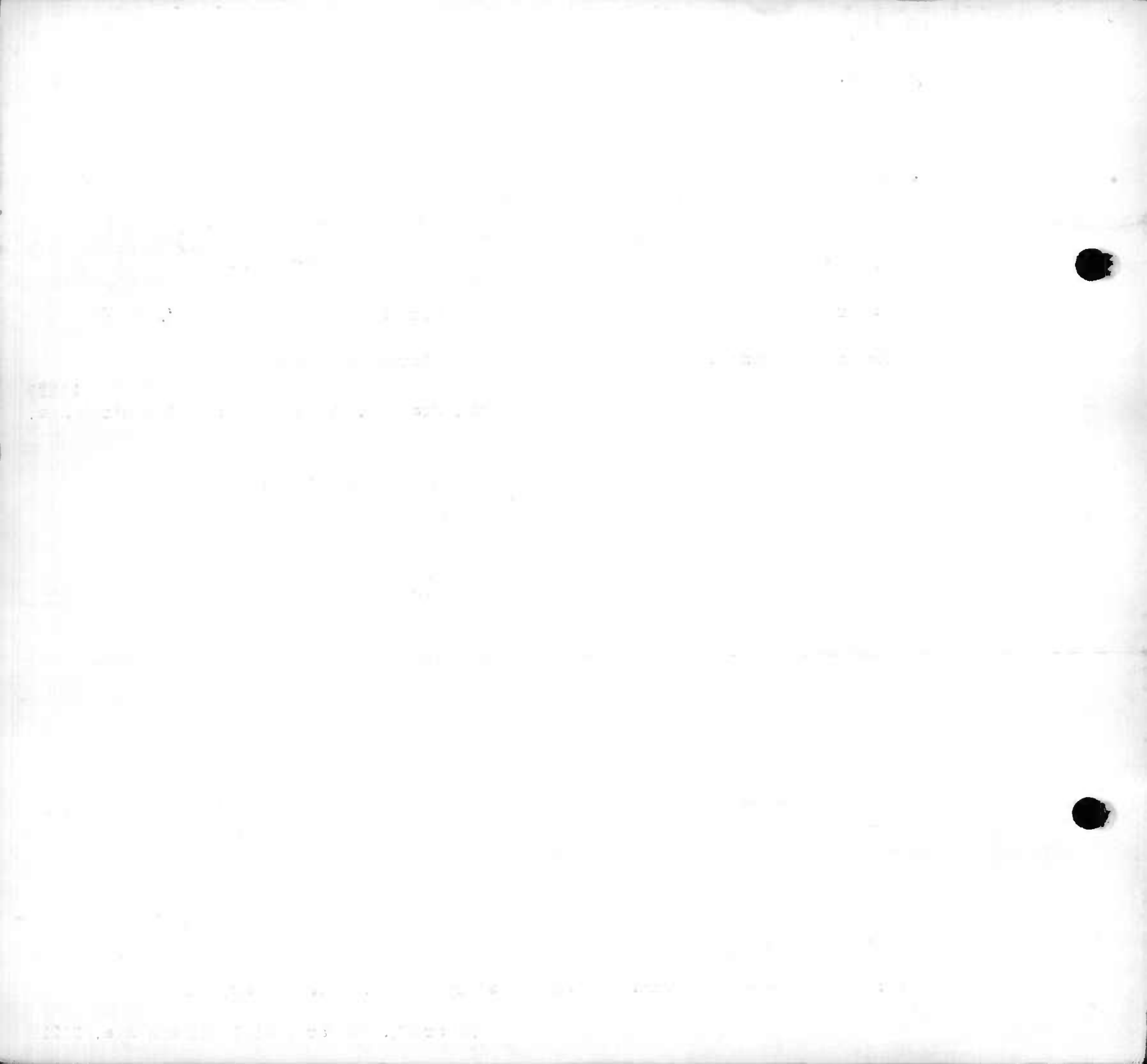
ST AGNES HOSPITAL-CATON & WILKINS

KIANG-YEN HUANG M.D.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08559		REG. NO. 72 08559	
W-236		72 08559		STATE OF MARYLAND-DEMD	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Grace Westerfelt		9/2/72 11:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Hood Convalescent Home 5313 Edmondson Ave. Balto. 21229			md Balto 5300		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			305 Bloomsbury Ave. 21228		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/22/1884	88 87	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert Strange			Caroline Yewell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				21227 Mrs. Grace W. Tausendschoen, 1240 Birch Ave.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLISM					
(B) DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA					
(C) A CVD					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/14/72 to 9/2/72 that (I) (we) last saw the deceased alive on 9/1/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John H. Hubbard M.D. DEGREE				9/5/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John H. Hubbard M.D.		5800 Edmondson Ave. Baltimore, Md.			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9-5-1972		Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 7 1972		Sidney W. Hubbard		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-630 72 08560		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 08560 STATE OF MARYLAND-DEME	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HART, Mr. William J. Sr.</b>		2. DATE AND HOUR OF DEATH <b>8/30/72 (Aug 30<sup>th</sup>) 3-15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2631</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b> <b>35</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Telephone Company clerk.</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>5-28-93</b> 9. AGE (In years last birthday) <b>79 yr.</b>	
13. FATHER'S NAME <b>THEODORE J HART</b>		14. MOTHER'S MAIDEN NAME <b>CECELIA KREIDWISE.</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-10-0902A</b>		17. INFORMANT <b>CATHERINE T. HART.</b> ADDRESS <b>485 7992</b>	
18. <b>721X+153,0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiopulmonary arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>(B) Generating wasting from paget</b> <b>(C) Disease, Arterio Sclerosis. Ca. Acute &amp; Chronic</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>8/22/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>intestinal obstruction (CA 60)</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/18/1972</b> to <b>8/30/1972</b> that (I) (we) last saw the deceased alive on <b>8/30/1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b> DEGREE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8/30/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. L. PADMARAJU M.D.</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-2-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Pinewood Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>			
25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>John C. Miller Inc 6415 Belair Rd. - 21206</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>G-626</b>      <b>72 08561</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p>		<p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 08561</b></p> <p>STATE OF MARYLAND - DEMO</p>
<p>BIRTH NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <b>Lexie Gregory</b></p>		<p>2. DATE AND HOUR OF DEATH <b>September 3, 1972 9<sup>25</sup> p. m.</b></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b></p> <p>C. CITY OR TOWN <b>Catonsville</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>42 Dunvegan</b></p>		
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>caucasian</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>7/30/1900</b></p>	<p>9. AGE (In years lost birthday) <b>72</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY _____</p>		<p>11. BIRTHPLACE (State or foreign country) <b>Penna.</b></p>
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>		<p>13. FATHER'S NAME <b>George Thompson</b></p>		
<p>14. MOTHER'S MAIDEN NAME <b>Elizabeth Withcum</b></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____</p>		
<p>16. SOCIAL SECURITY NO. _____</p>		<p>17. INFORMANT <b>June Parr</b> ADDRESS <b>42 Dunvegan Catonsville, Md.</b></p>		
<p>18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____</p>		
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic CVD, advanced</b></p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF _____ (B) _____ (C) _____</p>		
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes Mellitus</b></p>		<p>19A. DATE OF OPERATION <b>0</b></p>		
<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>		<p>20A. AUTOPSY? (Yes or No) <b>No</b></p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>		
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____</p>		
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? _____</p>		
<p>22. I certify that (I) (this hospital) attended the deceased from <b>7/17</b> 19 <b>67</b> to <b>9/3</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/3</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE <b>Herbert J. Levickas, M.D.</b></p>		<p>23B. DATE SIGNED <b>9/5/72</b></p>		
<p>23C. PHYSICIAN'S NAME (Type) <b>Herbert J. Levickas, M.D.</b></p>		<p>23D. ADDRESS <b>5404 East Drive, Arbutus, Maryland 21227</b></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>	<p>24B. DATE <b>9/6/72</b></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Edw. S. MacNabb</b></p>		
<p>25C. FUNERAL DIRECTOR ADDRESS <b>301 Frederick Ave. Catonsville, Md.</b></p>		<p>25D. _____</p>		

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>W-420</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08562</b>		STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <b>WILES, VERNON AGNEW</b>				2. DATE AND HOUR OF DEATH <b>SEPTEMBER 3, 1972 12:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>21228</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> <b>CATON &amp; WILKENS AVENUES</b> <b>BALTIMORE, MARYLAND 21229</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>10/16/02</b>		9. AGE (In years last birthday) <b>69</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLOTH EXAMINER</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL A WILES</b>				14. MOTHER'S MAIDEN NAME <b>ELIZA JONES</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-09-6046</b>		17. INFORMANT <b>BALTO MD 21229</b> ADDRESS <b>ST AGNES' RECORDS CATON &amp; WILKENS AVES</b>	
18. <b>427.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				(A) IMMEDIATE CAUSE <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: (C).....			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 2 1972</b> to <b>SEPTEMBER 3 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 3 1972</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <b>XXXXX</b> view the body after death.							
23A. SIGNATURE <b>S. N. MOUSSAVIAN, M.D.</b>				23B. ADDRESS <b>BALTO MD 21229</b> <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>		23C. DATE SIGNED <b>09/03/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9/6/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Good Shepherd</b>	
24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>			
25B. NAME OF REGISTRAR <b>Edw. S. MacNabb Sons, Inc.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>301 Frederick Rd. Catonsville, Md.</b>			

SEPTEMBER 2, 1972 12:10 A.

WILEY, VERNON JAMES

MARYLAND BALTIMORE 21228

BALTIMORE

320 BRUNNEN AVENUE

ST AGNES HOSPITAL  
CATCH & WILKES AVENUE  
BALTIMORE, MARYLAND 21228

10/16/02 60

MALE CAUCASIAN

MARYLAND

CLINTON EXAMINER

ELIZA JONES

DANIEL A WILKS

BALTD NO 21228

213-00-6006 ST AGNES RECORDS CATCH & WILKES

NO

CARDIOBIOCHEMISTRY AREA

QUESTIONS MUST BE ASKED

NO

SEPTEMBER 2 72

SEPTEMBER 2 72

SEPTEMBER 2 72  
XXXXX

09/02/72

BALTD NO 21228

2 N. WILKES

ST AGNES HOSPITAL CATCH & WILKES

E. W. WILKES, M.D.

Ellicott City, Maryland

Good She

9/6/72

Burial

Low S. Methodist Hosp, Inc.  
301 Frederick St. Baltimore, Md.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

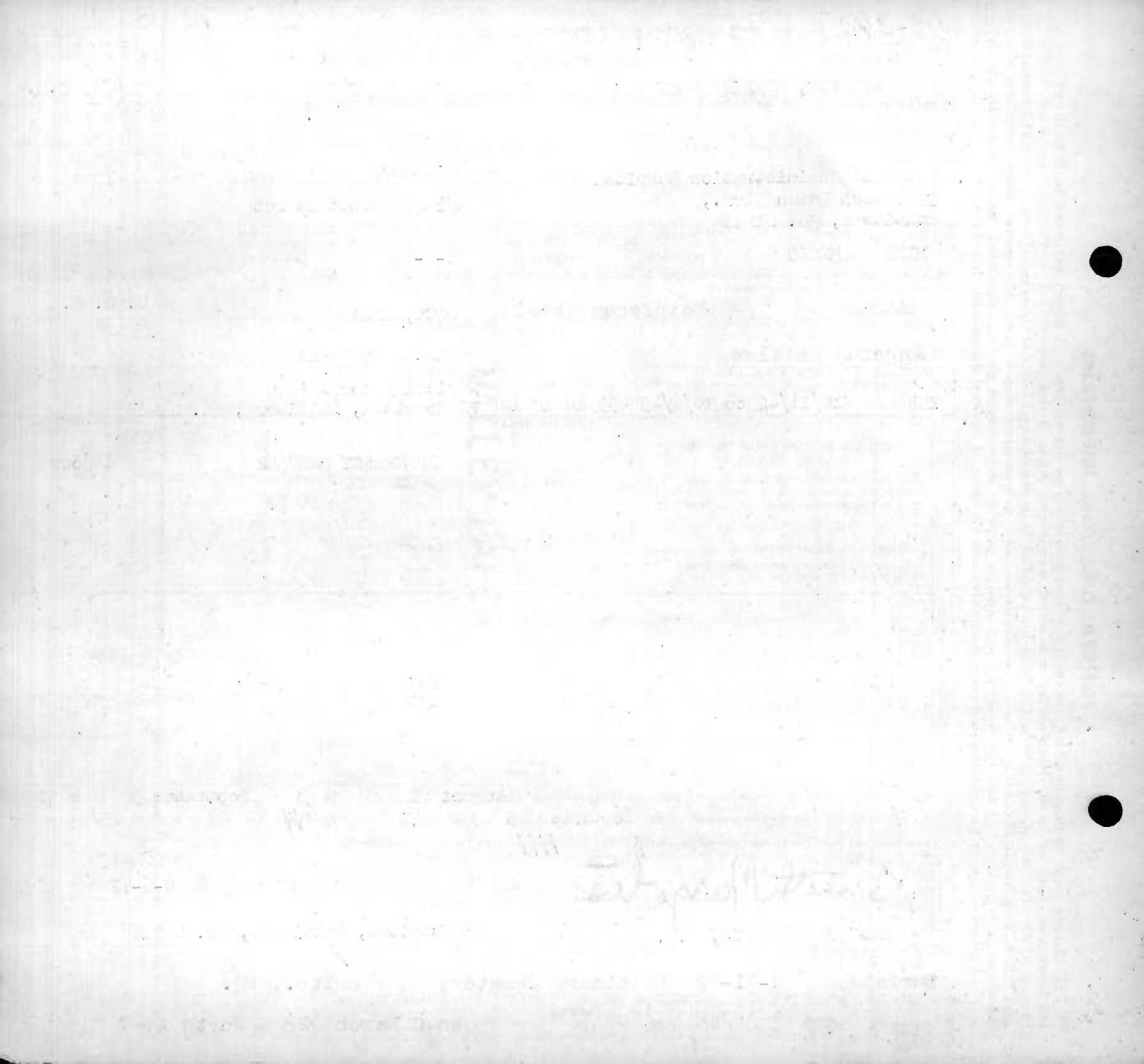
BALTIMORE CITY HEALTH DEPARTMENT		72 08563		REG. NO. 72 08563	
D-300		72 08563		STATE OF MARYLAND-DEME	
BIRTH NO.		72 08563		7 A M.	
1. NAME OF DECEASED (Type or Print)		Marie D. Dowdy		2. DATE AND HOUR OF DEATH 9-6-1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2629 E. Preston Street		21213			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-99	9. AGE (in years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry B. Doswell		14. MOTHER'S MAIDEN NAME Mary A. Fowlkes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH-4940 Eastern Ave. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I 1633 I CAUSE OF DEATH Anoxia DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) aspiration DUE TO, OR AS A CONSEQUENCE OF: (C) vomiting & regurgitation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours		19. DATE OF OPERATION 9/5/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction 20 to carcinoma sigmoid colon	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/4 1972 to 9/6 1972 that (I) (we) last saw the deceased alive on 9/6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ted Wingard		23B. DATE SIGNED 9/6/72			
23C. PHYSICIAN'S NAME (Type) Ted Wingard		23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224 Baltimore City Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-10-72		24C. NAME OF CEMETERY or CREMATORY Meherrin, Va.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. SEP 7 1972		25B. NAME OF REGISTRAR Wm C March	
25C. FUNERAL DIRECTOR Wm C March		25D. ADDRESS 928 E North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08564</b>	
BIRTH NO. <b>W-340</b>		72 08564	
1. NAME OF DECEASED (Type or Print) <b>WHITLOW, BENNIE LEROY</b>		2. DATE AND HOUR OF DEATH <b>9-5-72</b> <b>4:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>909</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-6-08</b> 9. AGE (In years last birthday) <b>64</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>WACO, TEXAS</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Langston Whitlow</b>		14. MOTHER'S MAIDEN NAME <b>Annie Purnell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b> <b>12/11/42 to 10/6/45</b>		16. SOCIAL SECURITY NO. <b>455 10 18 10</b>	
17. INFORMANT <b>Medical Records</b>		ADDRESS <b>VA Hospital, Baltimore, Md. 21218</b>	
18. <b>4550X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMBOLUS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>	
19A. DATE OF OPERATION <b>2 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>August 22</b> <b>19 72</b> to <b>September 5</b> <b>19 72</b> , that (1) (we) last saw the deceased alive on <b>September 5</b> <b>19 72</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Kenneth Margolis</b>		23B. DATE SIGNED <b>9-6-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>KENNETH MARGOLIS, M.D.</b>		23D. ADDRESS <b>VA Hospital, Baltimore, Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-11-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Boston</b>	
25C. FUNERAL DIRECTOR <b>Wm. C March</b>		ADDRESS <b>928 E North Ave.</b>	

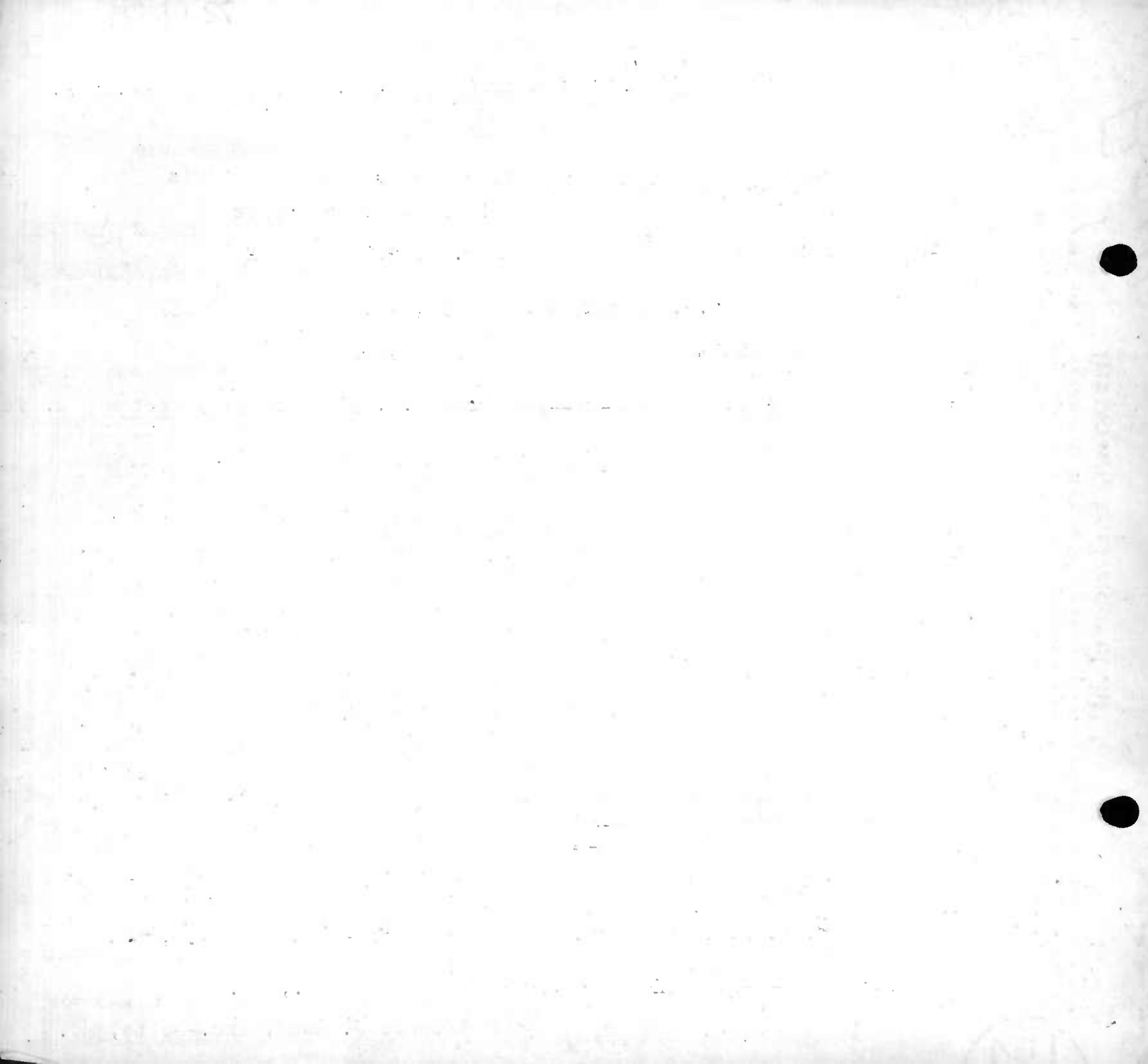


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-145		72 08565		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08565	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		ALOYSUS RAYMOND ALOYSIUS SPIELMAN		2. DATE AND HOUR OF DEATH Sept. 4, 1972 12.05 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		00 3313 Northway Drive		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3313 Northway Drive	
5. SEX male	6. RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1910	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY U.S. Postoffice		11. BIRTHPLACE (State or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Spielman		14. MOTHER'S MAIDEN NAME Eva Petri					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 212-01-4799		17. INFORMANT Mrs. R.A. Spielman 3313 Northway Drive			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH metastatic neoplastic disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma Rectum		Years 7 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6/15/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Rectum		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 1 - 71 19 to Sept 4 1972, that (I) (we) last saw the deceased alive on Sept 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.							
23A. SIGNATURE Dr. G. J. Sawyer Jr.		23B. DATE SIGNED 9/5/72					
23C. PHYSICIAN'S NAME (Type) Dr. G. J. Sawyer Jr.		23D. ADDRESS 4808 Harford Rd. Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1972		25B. NAME OF REGISTRAR Sidney H. Harkness		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Balto, Md.		ADDRESS	



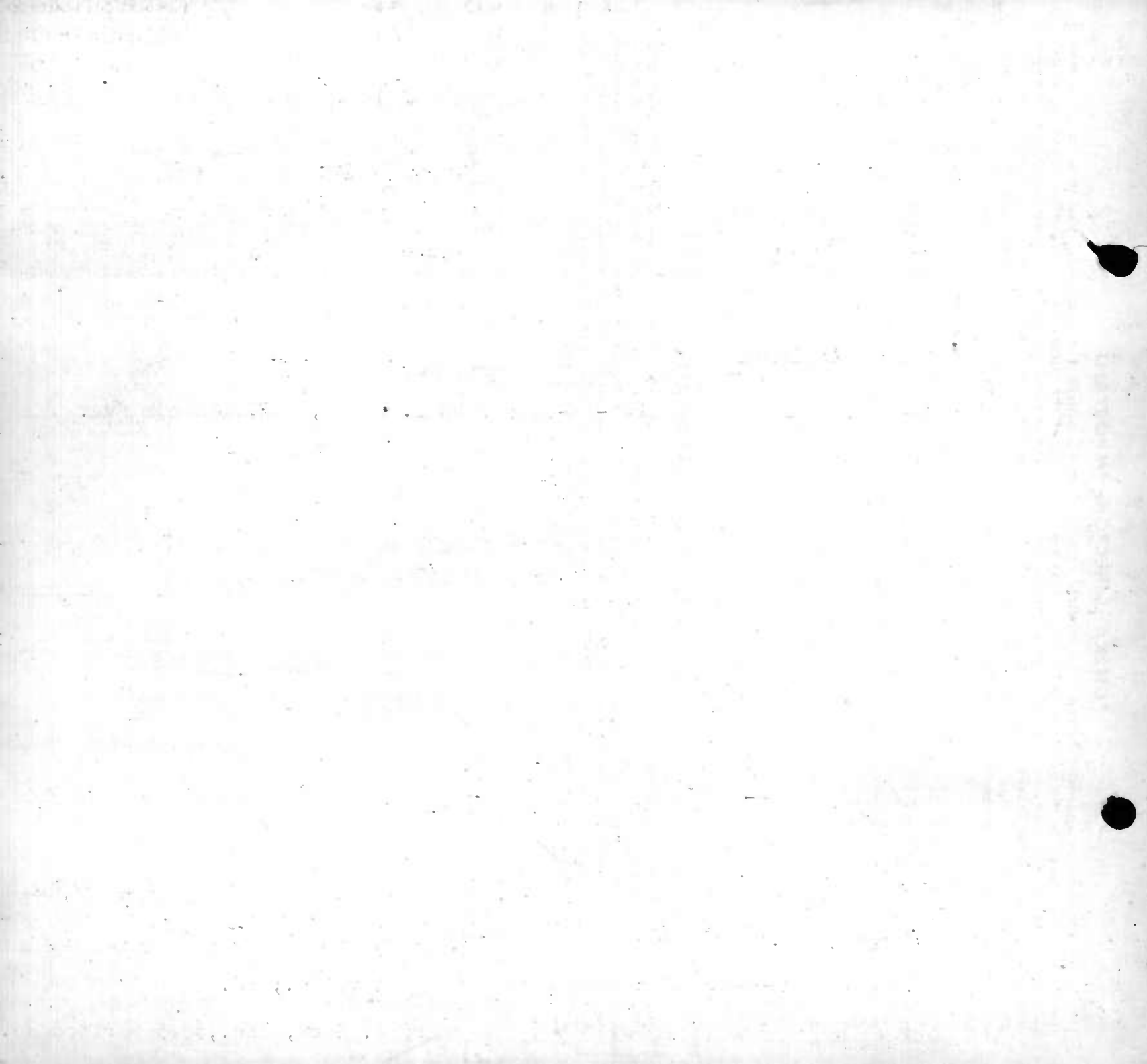




# FUNERAL DIRECTOR: IMPORTANT

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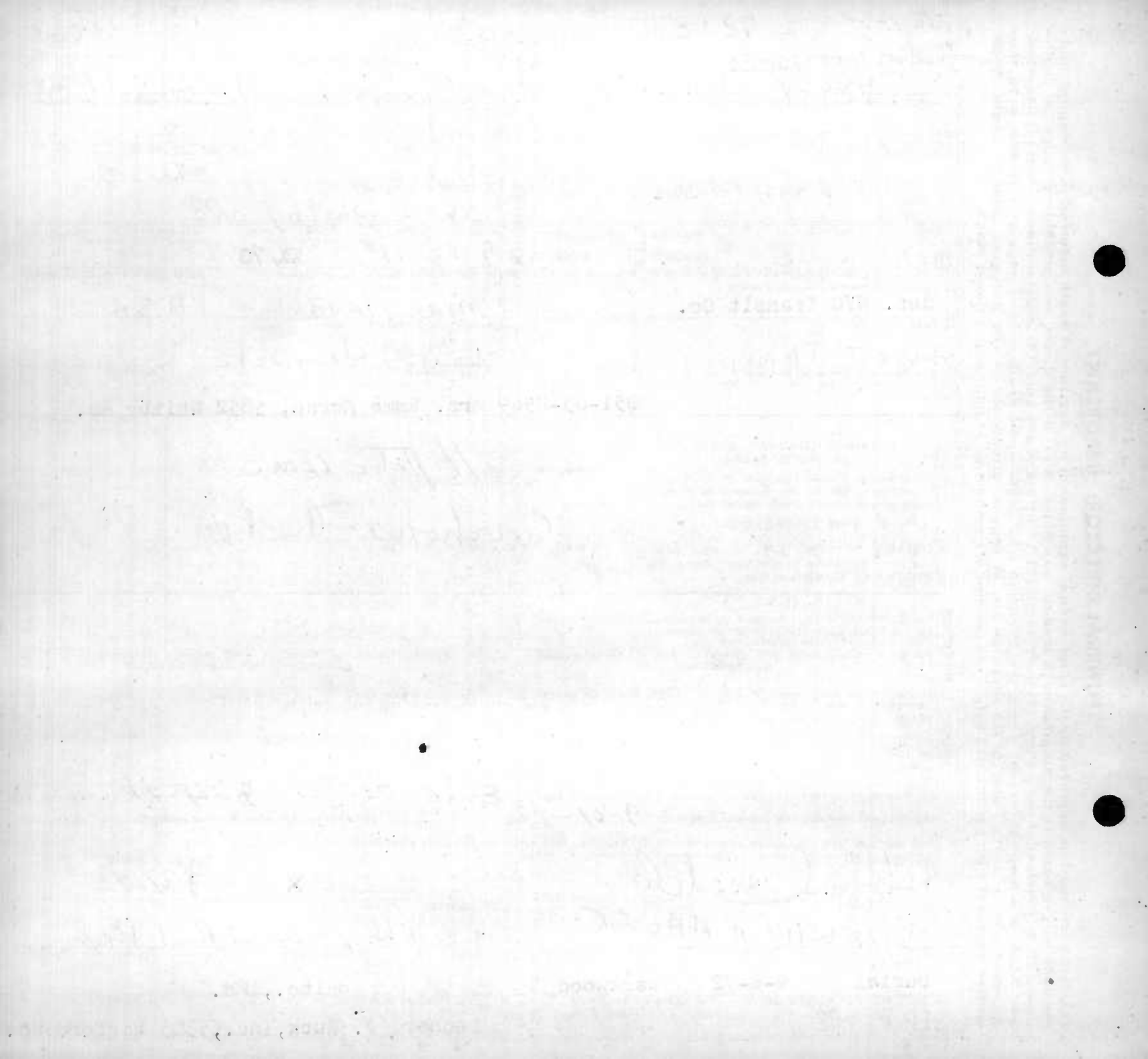
0-520		72 08566		BALTIMORE CITY HEALTH DEPARTMENT		72 08566	
BIRTH NO.		1. NAME OF DECEASED (Type or print)		2. DATE AND HOUR OF DEATH		REG. NO.	
		MARGARET M. OWENS		Sept 4 / 1972 8:00 P.M.		STATE OF MARYLAND-DHMH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION HAMILTON NURSING CENTER 90 CENTER				A. STATE Md B. COUNTY 27 33			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4627 ELSRODE AVE 21214			
5. SEX F	6. RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-90	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? Ireland	
13. FATHER'S NAME John Callahan				14. MOTHER'S MAIDEN NAME Margaret Cohen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-5515		17. INFORMANT John P. Owens, 4627 Elsrade Ave.			
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I. AS CAUSE - enlarged heart (A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: acute & chronic (B) CARDIAC FAILURE DUE TO OR AS A CONSEQUENCE OF: 2. GEN. FAILURE (C) GEN. FAILURE II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 19 65 to Sept 4 19 72 that (I) last saw the deceased alive on Aug 30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald W. Muntzer				23B. DATE SIGNED Sept 4 / 1972			
23C. PHYSICIAN'S NAME (Type) DONALD W. M. MUNTZER				23D. ADDRESS 3009 EVERGREEN AVE BALTO MD 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1972		25B. NAME OF REGISTRAR Sidney H. Norton		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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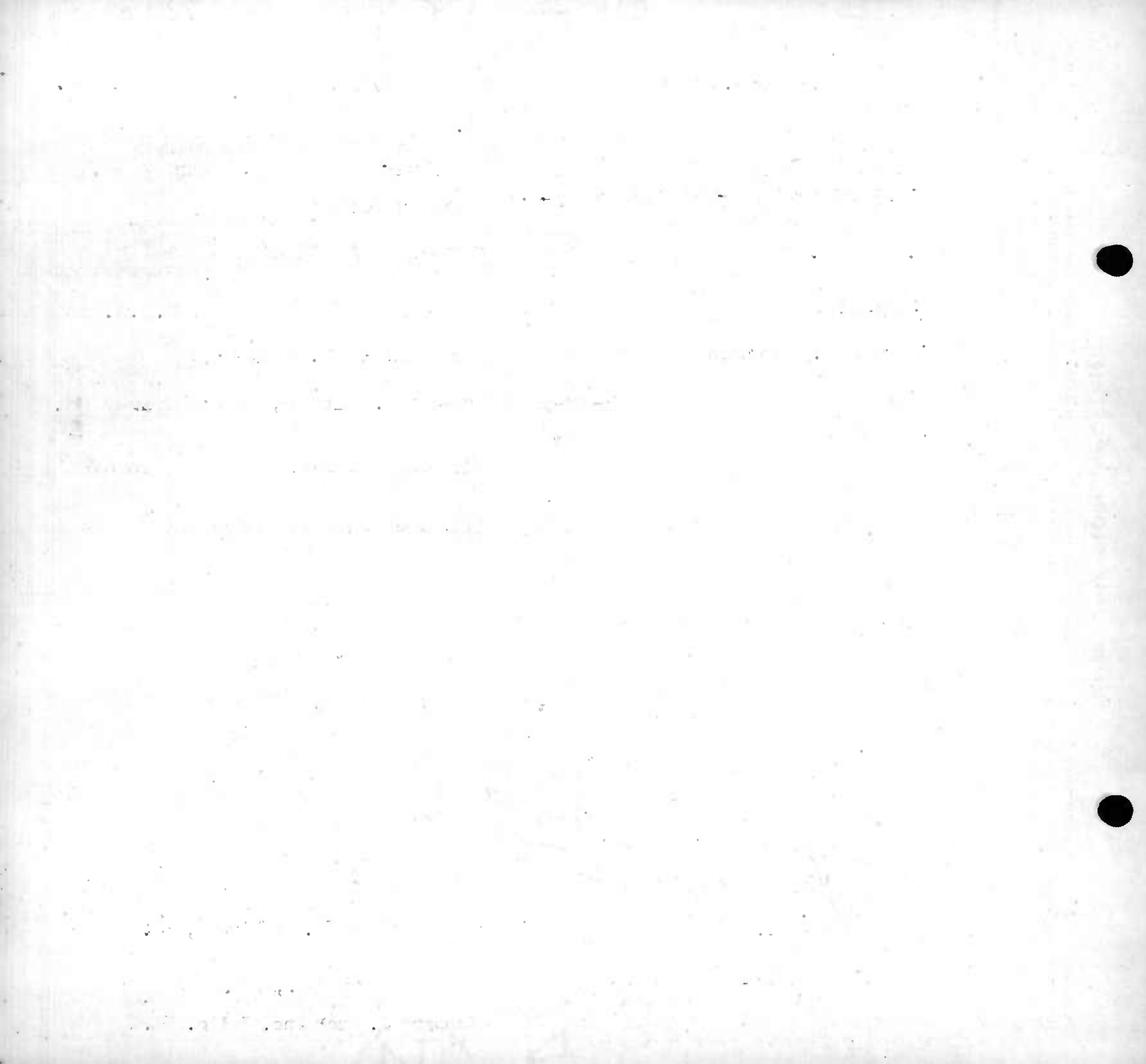
BALTIMORE CITY HEALTH DEPARTMENT				72 08567		REG. NO. 72 08567	
7-455				72 08567			
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <u>August Fleming</u>				2. DATE AND HOUR OF DEATH <u>Sept. 4, 1972 11:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>BALTO</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3 Mercy Hospital, Inc.</u>				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>5652 Whitby Rd</u>			
5. SEX <u>MALE</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-13-01</u>	9. AGE (If years lost birthday) <u>70</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. NYC Transit Co.</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Fleming</u>				14. MOTHER'S MAIDEN NAME <u>Louise Hammel</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>051-03-8549</u>		17. INFORMANT <u>Mrs. Emma Moran, 5652 Whitby Rd.</u>	
18. <u>571.81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u> 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>0</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hepatic coma.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cirrhosis - The liver.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-26-72</u> 19 to <u>9-4-72</u> 19, that (I) (we) last saw the deceased alive on <u>9-4-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Shawn Malek</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-4-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>SHAWN M. MALEK</u>				23D. ADDRESS <u>Mercy Hosp. 301 St. Paul Place</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-8-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1972</u>				25B. NAME OF REGISTRAR <u>Shawn Malek</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc.</u>	
				ADDRESS <u>5305 Harford Rd.</u>			



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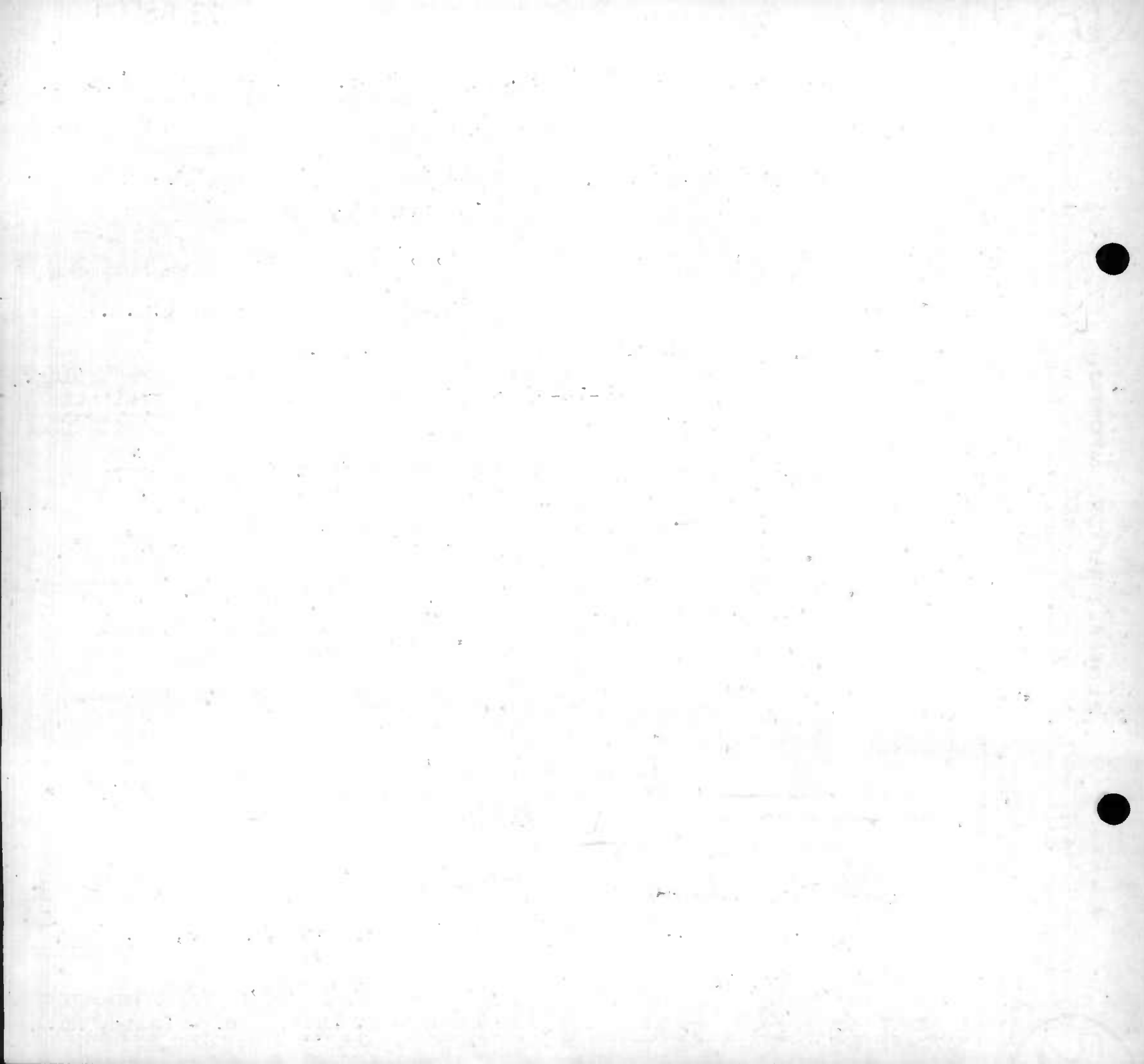
<div style="display: flex; justify-content: space-between;"> <span><b>D-355</b></span> <span><b>72 08568</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b>  <b>REG. NO. OF MARYLAND - DEATH</b> </div>			
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>Dorothy C. Ditman</b>		2. DATE AND HOUR OF DEATH <b>9/3/72</b>   <b>7:20 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2423 Wellbridge Wellington Gate Apt.C</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2737</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2423 Wellbridge</b>	
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09-01-07</b> 9. AGE (In years lost birthday) <b>65</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas W. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth P. Ennis</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-70-9804</b>	
17. INFORMANT <b>Thomas L. Ditman, 1820 Wendover Rd.</b>		ADDRESS	
18. <b>188X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Carcinomatous</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Cx Bladder wall w/rd hyperplasia under-</b> DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unkn.</b>	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>7-19</b> 19 <b>72</b> to <b>9-3</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9-2</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>John C. Hyle</b>		23B. DATE SIGNED <b>9-5-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John C. Hyle</b>		23D. ADDRESS <b>7527 Belair Rd. Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-7-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto., Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 08569 STATE OF MARYLAND-DD-44	
BIRTH NO. 5-362		72 08569			
1. NAME OF DECEASED (Type or Print) HERBERT W STARK		2. DATE AND HOUR OF DEATH Sept. 4, 1972 10.30 p. m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1102			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 GOULD'S CONVALESARIUM		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 708 Cathedral St			
5. SEX male	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1874	9. AGE (In years lost birthday) 97	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ? Stark		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-8767A		17. INFORMANT Mr August Conomos 750 Equitable Bldg.	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Brain Syndrome; Severe Dementia		CAUSE OF DEATH (A) IMMEDIATE CAUSE Due to, or as a consequence of: Atherosclerotic Heart Disease (B) Generalized Atherosclerosis (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/22/1972 to 9/4/1972, that (I) (we) last saw the deceased alive on 8/22/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Dr. Albert B. Bradley		23B. DATE SIGNED 9/5/72		23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/8/72		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. SEP 7 1972		24F. NAME OF REGISTRAR Sidney Wharton	
24G. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Balto, Md.		24H. ADDRESS		24I. DATE	

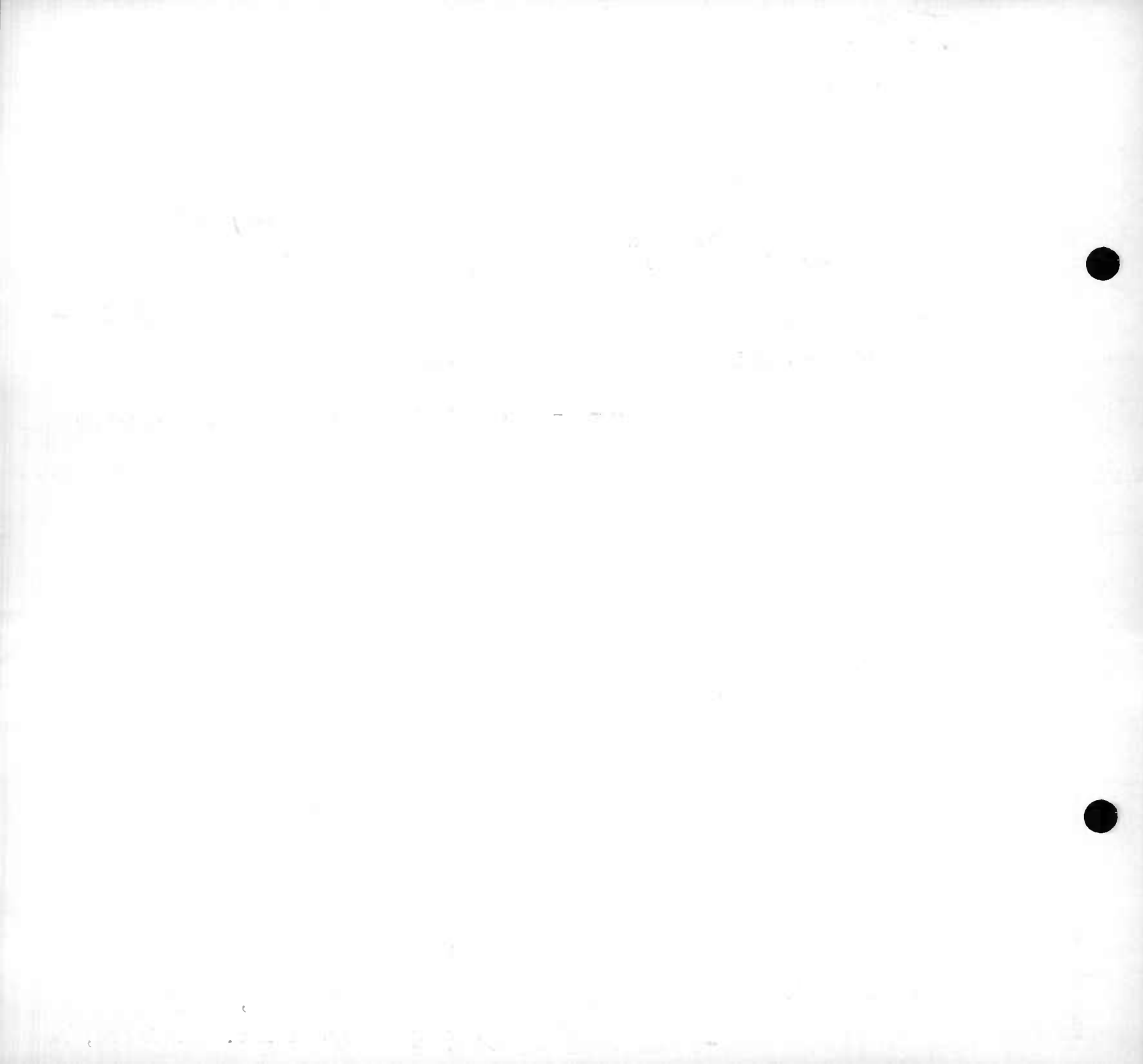




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

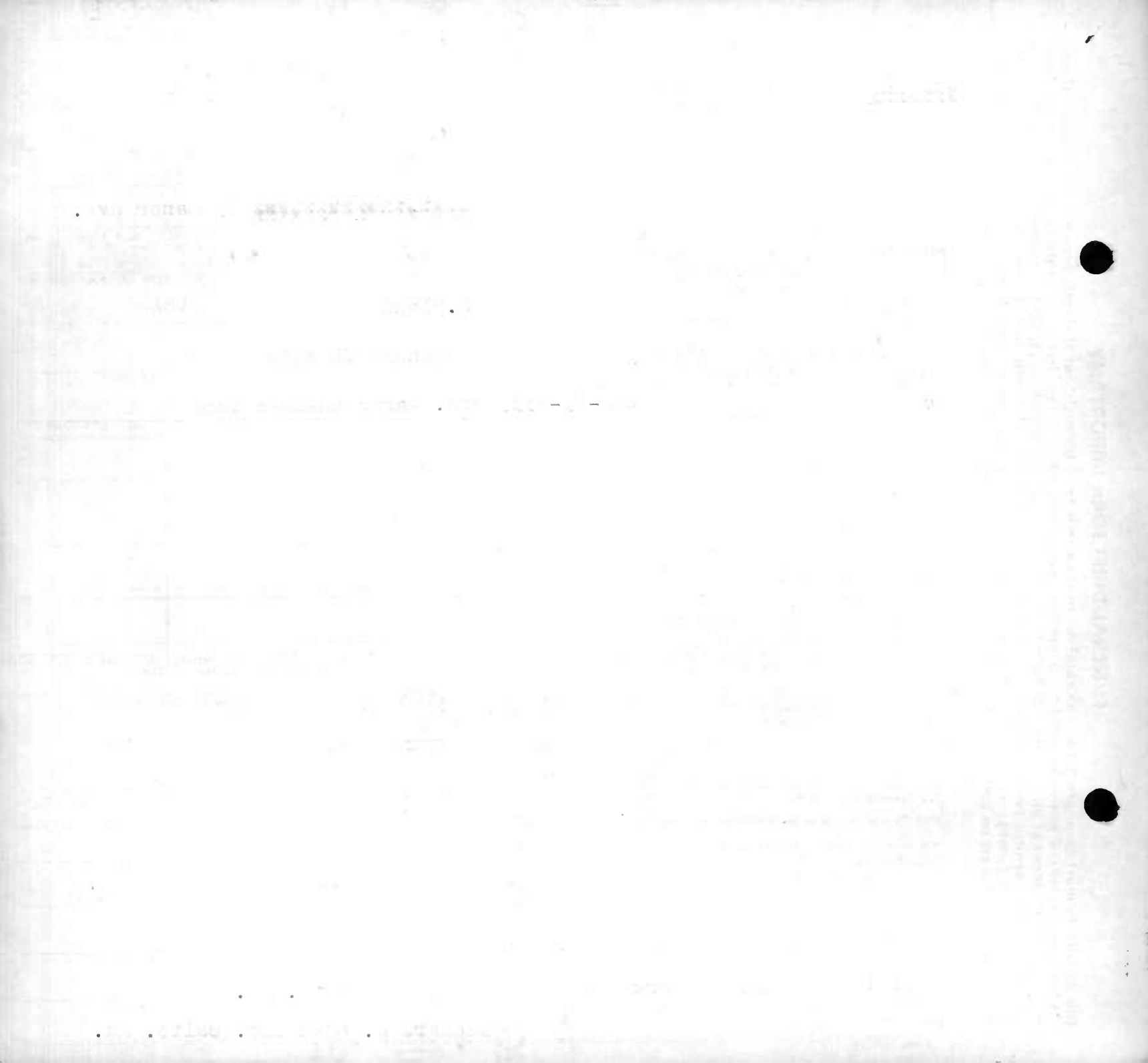
BALTIMORE CITY HEALTH DEPARTMENT				72 08570		72 08570	
T-253				72 08570		72 08570	
BIRTH NO.				72 08570		72 08570	
1. NAME OF DECEASED (Type or Print)				B		2. DATE AND HOUR OF DEATH	
KATHERINE TOWSHEND				SEPT 5, 1972		12.15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		702	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland		B. COUNTY	
Lutheran Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
46				E. STREET AND NUMBER 2628 McElderry St.			
5. SEX F		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-13-05	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SALESLADY		DEPT. STORE		MD		U.S.A.	
13. FATHER'S NAME John G Vogel				14. MOTHER'S MAIDEN NAME Bernice Fields			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-26-6941		17. INFORMANT Mrs Mary Jane Breece 3 Sipple Ave	
18. CAUSE OF DEATH 183.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION Sept 4, 1972 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED G.I. obstruction 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from Sept 2, 1972 to Sept 5, 1972. that (I) (we) last saw the deceased alive on Sept 5, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Boonyong Phruithithada 23B. DATE SIGNED Sept 5, 72 23C. PHYSICIAN'S NAME (Type) BOONYONG PHRUITHITHADA 23D. ADDRESS Lutheran Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/8/72 24C. NAME OF CEMETERY or CREMATORY Oaklawn 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. SEP 7 1972 25B. NAME OF REGISTRAR Leonard J. Ruck Inc. 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Md							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08571		REG. NO. 72 08571		STATE OF MARYLAND-DEME	
BIRTH NO. C-260		1. NAME OF DECEASED (Type or Print) <b>Joseph Stanley Chesser</b>		2. DATE AND HOUR OF DEATH <b>9/5/72 11:15 PM</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BAITIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <del>XXXXXXXXXXXX</del> -15 Manor Ave.					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03-25-11</b>		9. AGE (in years last birthday) <b>61</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>CLARENCE Chesser</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Chesser</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-05-6335</b>		17. INFORMANT ADDRESS <b>Mrs. Sarah Chesser same</b>					
18. <b>200.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hemorrhage</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) <b>Basophil Cell Sarcoma of Stomach</b> DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? <b>Sept 3</b>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Sept 3</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 15</b> 19 <b>72</b> to <b>Sept 5</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>11:45 PM Sept 15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>RICHARD SCOTT JOHANNES</b>				23B. DATE SIGNED <b>9/5/72</b>		23C. PHYSICIAN'S NAME (Type) <b>RICHARD SCOTT JOHANNES</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/8/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>		25B. NAME OF REGISTRAR <b>Lidney In...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Luck Inc. Balto. Md.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08572		STATE OF MARYLAND - DEHM	
BIRTH NO. J-620				72 08572			
1. NAME OF DECEASED (Type or Print) JAWORSKI, LEON J.				2. DATE AND HOUR OF DEATH SEPTEMBER 3, 1972 11:30P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL 40				A. STATE MARYLAND B. COUNTY ANNE ARUNDEL COUNTY			
				C. CITY OR TOWN PASADENA		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER BOX 165 RT 9 POWHATAN BEACH 5200			
5. SEX MALE	6. RACE CAUCASIAN	7. <del>NEVER MARRIED</del> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 04 01 93	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		10B. KIND OF BUSINESS OR INDUSTRY MERCHANT MARINE		11. BIRTHPLACE (State or foreign country) MARYLAND Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LUDWIG JAWORSKI				14. MOTHER'S MAIDEN NAME Mary Napowolski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219015015A		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Anteroseptal and Inferior MI (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that XX (this hospital) attended the deceased from SEPTEMBER 3, 1972 to SEPTEMBER 3, 1972, that XX (we) last saw the deceased alive on SEPTEMBER 3, 1972 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE [Signature]				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/4/72	
23C. PHYSICIAN'S NAME (Type) AGATON H. ESCOBAR, M.D.				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-72		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd		ADDRESS	

SEPTEMBER 3, 1935

JANUARY 1, 1936

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>S-316</span> <span>72 08573</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 72 08573 STATE OF MARYLAND-DEATH	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <b>STAUFFER ALOREY L.</b>		2. DATE AND HOUR OF DEATH <b>SEPT. 4, 1972 8:00 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b> <b>43</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____ C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3612 10th ST</b>	
5. SEX <b>F</b> 6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-16</b> 9. AGE (In years, last birthday) <b>56</b>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christian W. Ott</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gray</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <b>215 01 9213</b> 17. INFORMANT <b>Ronald B. Stauffer</b> ADDRESS <b>4 Cambridge Ct. 21207</b>	
18. <b>255.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>Cerebral hemorrhage &amp; focal infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive encephalopathy</b> <b>Cardiac hyperfunction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>4 Sept 72</b> 19 to <b>4 Sept 72</b> 19, that (I) (we) last saw the deceased alive on <b>4 Sept 72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>J R [Signature] M.D.</b> DEGREE _____		23B. DATE SIGNED <b>4 Sept 72</b>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS _____	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/8/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Good Sheppard Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>St. Johns Lane Ellicott City.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>	
25C. FUNERAL DIRECTOR <b>McCully</b> ADDRESS <b>237 Patapsco Ave 21225</b>		25D. _____	





1

E-152 72 08574 STATE OF MARYLAND-DEMR BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08574

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD EVANS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year September 3, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour September 3, 1972 2:15 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan 20, 1932		10. AGE (In years lost birthday) 40	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		14B. KIND OF BUSINESS OR INDUSTRY Restaurant	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean War		17. SOCIAL SECURITY NO. 217-26-5512	
18. INFORMANT Bertha Baker		ADDRESS 1333 Ramsay St. 21223	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Tavern	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Ramsey Street		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9-3-72 1:45 A.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED September 3, 1972 ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/7/72	
24C. NAME OF CEMETERY or CREMATORY Crestlawn Gardens		24D. LOCATION (City, town, or county) (State) Howard Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 7 1972		25B. NAME OF REGISTRAR A. J. H. H. H.	
25C. FUNERAL DIRECTOR Walters Funeral Home		ADDRESS Pratt & Stricker Streets 21223	

VS 151-REV. 7/1/68

10-4-1972 - Letter from the Office of the Chief Medical Examiner,  
Peter Lipkovic, M.D., Assistant Medical Examiner HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-660 72 08575				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08575	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				THOMAS BROWER		9-4-72 4:40PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND 7000 TALBOT			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
OXFORD				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				P. O. BOX 367			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9-30-04	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
Civil service		Post Office		67		N.Y.	
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HENRY BROWER				SEARSALL ELLEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
no				213-48-2389		Mrs. Elizabeth Kish, Oxford, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		20 minutes	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:		14 hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) 1/2 Surgery for transitional cell ca.		15 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Acute renal failure		12-13 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
9/3/72		Wound dehiscence, peritonitis		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from September 2, 1972 to September 4, 1972 that (I) (we) lost saw the deceased alive on September 4, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
David V. Wray M.D.				9/4/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DAVID V. WRAY M.D.				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/7/1972		Oxford		Oxford, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 7 1972		Dorothy Johnson		Wayne Funeral Home, Easton, Md.			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT C-636 72 08576 CERTIFICATE OF DEATH				REG. NO. 72 08576 STATE OF MARYLAND - DILIG
1. NAME OF DECEASED (Type or Print) <b>Victoria Carter</b>		2. DATE AND HOUR OF DEATH <b>September 3, 1972 8:45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Caton Manor Nursing Center 3330 Wilkens Avenue Baltimore, Maryland 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1420 Ceddox Street Baltimore, Md. 21226</b>		
5. SEX <b>Female</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/3/1892</b>	9. AGE (In years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Smith</b>		
14. MOTHER'S MAIDEN NAME <b>Ellen Rooney</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>218-22-4779</b>		17. INFORMANT <b>Joseph Carter</b> ADDRESS <b>866 Washington Blvd. Baltimore, Md. 21230</b>		
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Esophagus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma Esophagus</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>April 1972</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cc of Esophagus</b>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>6/19</b> 19 <b>53</b> to <b>9/3</b> 19 <b>72</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>8/31</b> 19 <b>72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.				
23A. SIGNATURE <b>John P. Unlock Jr.</b>		23B. DATE SIGNED <b>9/5/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. John P. Unlock Jr.</b>
23D. ADDRESS <b>1227 Washington Blvd., Balto., Md. 21223</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>9/6/1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>5501 Frederick Rd., Balto., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>		25B. NAME OF REGISTRAR <b>Dr. J. H. F. H.</b>		25C. FUNERAL DIRECTOR <b>Mc Gully F. H. 237 Patapsco Ave., Balto. 21225</b>

Washington, D.C.

September 1, 1954

Dear Mr. [Name]

I am very pleased to

hear from you and

thank you for your

letter of the 26th.

I am sure that you

will find the enclosed

of interest.

Sincerely,

[Signature]

[Name]

[Title]

[Address]

[City]

[State]

[Zip]

[Phone]

[Fax]

[Telex]

[Cable]

[Radio]

[TV]

[Internet]

[Email]

[Social Media]

[Other]

[Contact Info]

# FUNERAL DIRECTOR: IMPORTANT

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D-653 72 08577		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		72 08577 REG. NO. <b>STATE OF MARYLAND-DEMH</b>
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		<b>DURAND, JAMES</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVENUE BALTIMORE MARYLAND 21229</b>		A. STATE <b>MARYLAND</b>		
		B. COUNTY <b>ANNE ARUNDEL</b>		
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>08 16 89</b>		9. AGE (In years lost birthday) <b>83</b>		10. If Under 1 Yr. Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212 34 9246</b>		17. INFORMANT <b>&amp; WILKENS AVENUE 21229 ST. AGNES HOSPITAL RECORDS CATON</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Capillary &amp; myocardial infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Capillary</i> (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 5 19 72</b> to <b>SEPTEMBER 5 19 72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 5 19 72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the cause stated above. <input checked="" type="checkbox"/> (We) (did) (dXXX) view the body after death.				
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <b>9/8/72</b>		23C. PHYSICIAN'S NAME (Type) <b>RIGUER HEREDIA MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/8/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Frederick Road Patto 21229</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>		
25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <b>Mcnelly 237 Patapsco Ave 21225</b>		



SEPTEMBER 2 1957

HARVARD AND ST. ANNE'S

ST. ANNE'S HOSPITAL

505 VERMONT AVENUE

CHICAGO, ILL.

U.S.A.

ITALY

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OWNER

ST. ANNE'S HOSPITAL RECORDS DEPT.  
505 VERMONT AVENUE

NO

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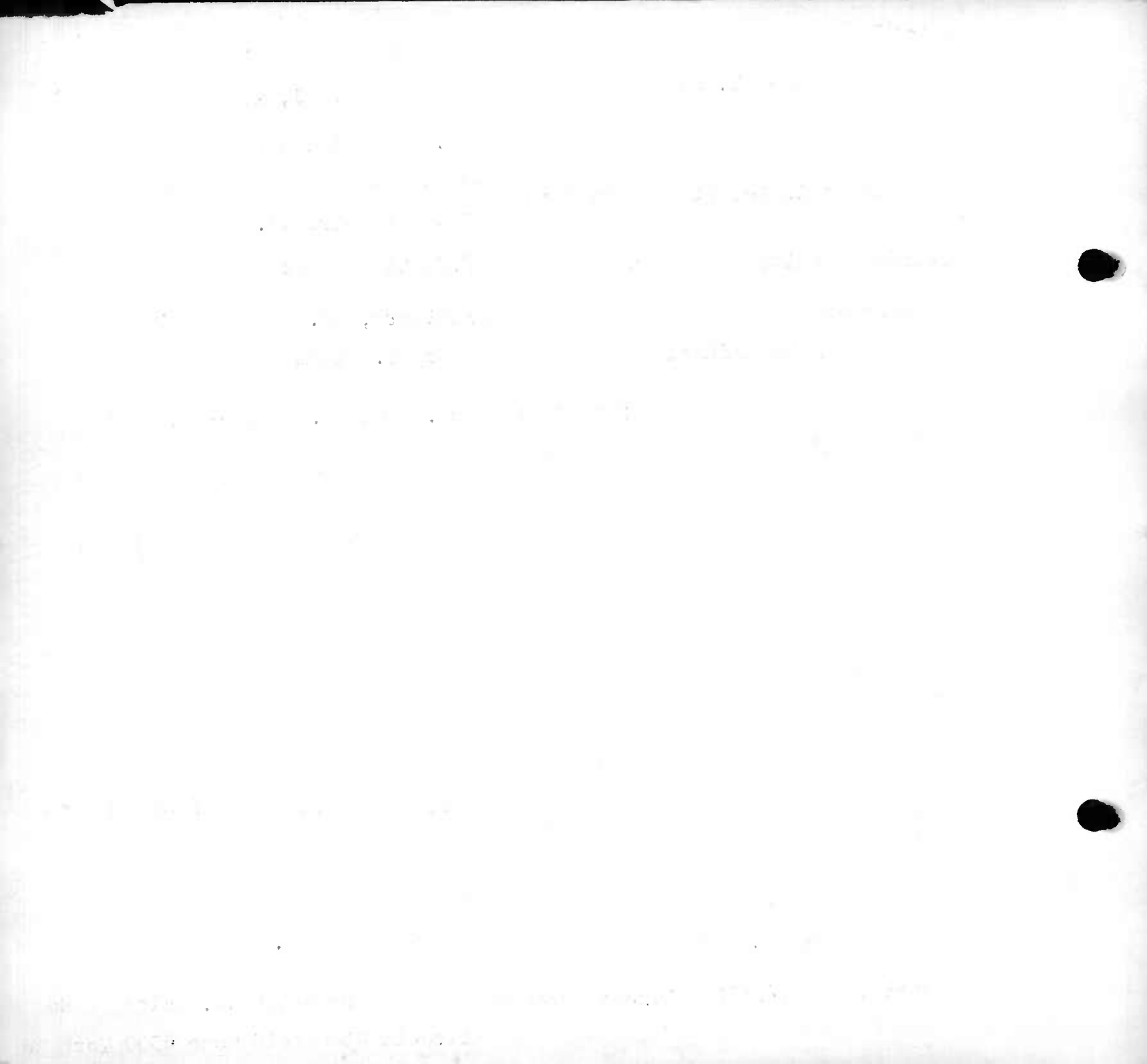
*[Handwritten signatures and notes]*



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08578	
0-235 72 08578				CERTIFICATE OF DEATH	
STATE OF MARYLAND-DEHM				M.	
1. NAME OF DECEASED (Type or Print)		Mae V. Ogden		2. DATE AND HOUR OF DEATH Sept 3, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
90 House in the Pines Belvedere				Md. Baltimore 2731	
5. SEX Female		6. RACE White		C. CITY OR TOWN Baltimore	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/1882		9. AGE (In years last birthday) 90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 3219 Berkshire Rd.	
13. FATHER'S NAME John Hoffman		14. MOTHER'S MAIDEN NAME Mary I. Bloom		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212141681		17. INFORMANT Mrs. Edwin H. Perlins Jr Same		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Antecedent causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks years					
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1972 to Sept 3 1972 that (I) (we) last saw the deceased alive on Sept 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leon A. Kochman				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Leon A. Kochman				23D. ADDRESS 7945 Stevenson Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/5/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Cemetery	
24D. LOCATION Frederick Rd. Balto Md		24E. DATE REC'D BY HEALTH DEPT. SEP 7 1972		24F. NAME OF REGISTRAR Mitchell Whedefeld	
24G. FUNERAL DIRECTOR ADDRESS 6500 York Rd		24H. DATE		24I. NAME	



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D-450		72 08579		BALTIMORE CITY HEALTH DEPARTMENT		72 08579	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Delaney, John J.</u>				2. DATE AND HOUR OF DEATH <u>9-3-72</u> <u>1:10 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>2702</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>3022 Weaver. Ave.</u>			
5. SEX <u>m</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-19-1925</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PLAINCLOTHESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CITY POLICE DEPT</u>		9. AGE (In years last birthday) <u>47</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>	
13. FATHER'S NAME <u>James Delaney</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>6-28-1945-2-19-1947</u>				16. SOCIAL SECURITY NO. <u>217-26-9793</u>		17. INFORMANT <u>MRS. ANNA M. DELANEY</u>	
18. <u>154.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>acute mi i ventric</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Ca. pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 5 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (netify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) lost saw the deceased olive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William H. Bouchele MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-3-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>W. BOUCHELLE</u>				23D. ADDRESS <u>MERCY HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-7-72</u>		24C. NAME of CEMETERY or CREMATORY <u>NEW CATHEDRAL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 7 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Whitman</u>		25C. FUNERAL DIRECTOR <u>J. J. Kallan</u>		ADDRESS <u>Condo 5444 BELAIR Rd.</u>	

Delaney, John J.

3033 Western Ave.  
B.H.  
M.D.

7-19-44

M.D.

Julia O'Donnell

James Delaney

M W

Mercy

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>M-530</b>		BALTIMORE CITY HEALTH DEPT. <b>72 08580</b>		REG. NO. <b>72 08580</b>	
1. NAME OF DECEASED (Type or Print) <b>MUNDY, JAMES RUFUS</b>			2. DATE AND HOUR OF DEATH <b>SEPTEMBER 3, 1972 3:00 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b> C. CITY OR TOWN <b>ELLCOTT CITY</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>10217 CABERY ROAD</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1921</b>	9. AGE (In years lost birthday) <b>50</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GAS &amp; ELECTRIC</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
13. FATHER'S NAME <b>JAMES P. MUNDY</b>			14. MOTHER'S MAIDEN NAME <b>GUSSIE CLARKE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W W 2</b>		16. SOCIAL SECURITY NO. <b>214-12-9560</b>		17. INFORMANT <b>BALTO MD 21229</b>	
18. CAUSE OF DEATH <b>412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Old Patient &amp; misdiagnosed MI</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>SEPTEMBER 2</b> 19 <b>72</b> to <b>SEPTEMBER 3</b> 19 <b>72</b> , that <b>X</b> (we) lost saw the deceased alive on <b>SEPTEMBER 3</b> 19 <b>72</b> and that <b>XXX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>XX</b> (We) (did) <b>XXXX</b> view the body after death.					
23A. SIGNATURE <i>Miscellaneous</i>				23B. DATE SIGNED <b>9/3/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>AGATON H. ESCALANTE, M.D.</b>				23D. ADDRESS <b>ST. AGNES HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/6/1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Mount Olive Cemetery</b>	
24D. LOCATION <b>Randallstown Balto. Co., Md.</b>		24E. NAME OF REGISTRAR <b>25576</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Hooton</b>		25C. FUNERAL DIRECTOR <b>8728 Liberty Road ADDRESS 21133 Loring Byers Funeral Directors, P. A.</b>	

COMMON

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1017 CHERY ROAD

ISSN 0013-788X

NAME \_\_\_\_\_ DATE \_\_\_\_\_

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NORTH CAROLINA

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21-11-250-27 AGNES, REYNOLDS CATON

S 9304-37932

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VS 151-REV. 7/1/68

## MEDICAL CERTIFICATION



Handwritten signature or initials.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

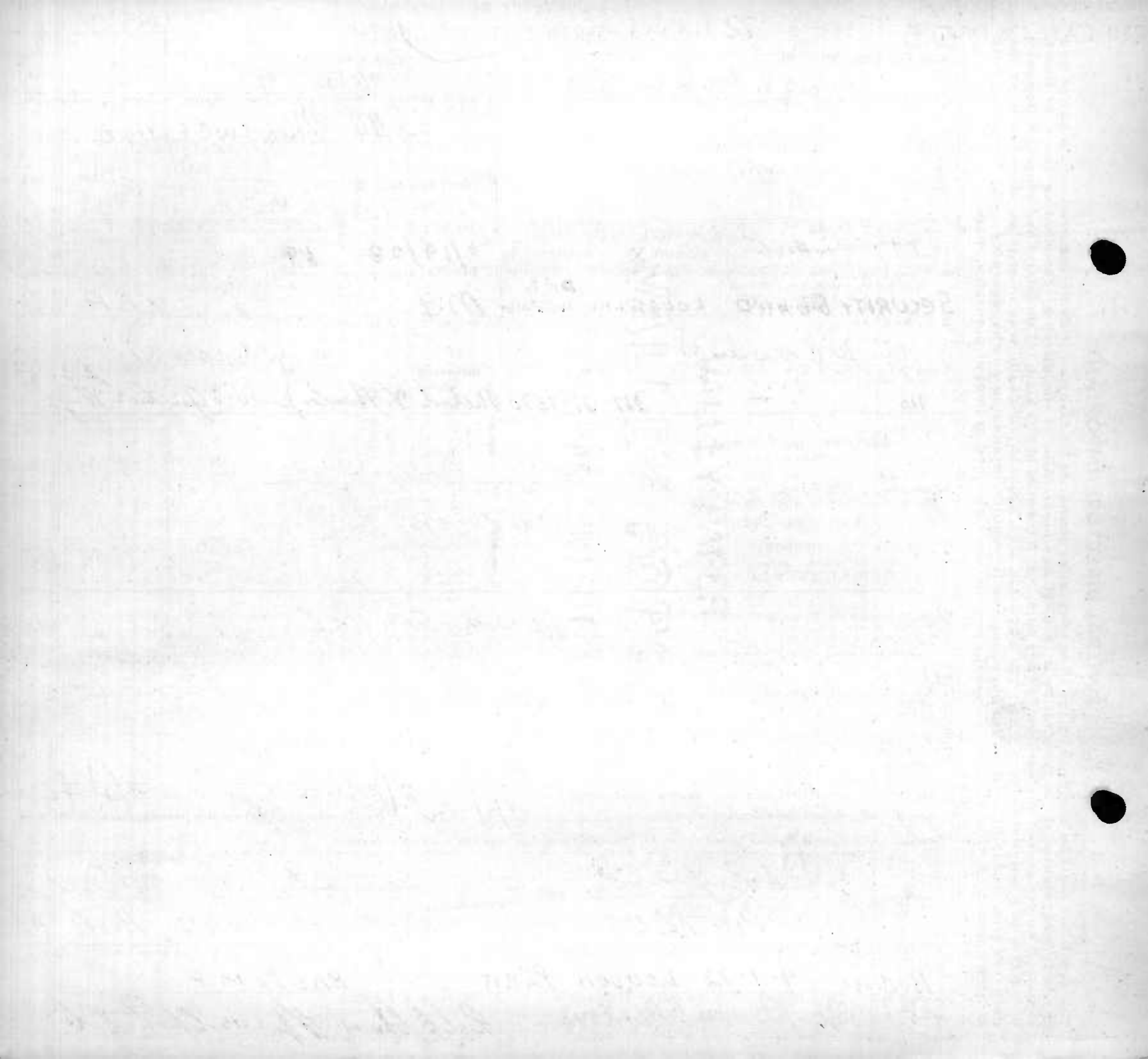
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        | REG. NO. 72 08582<br>STATE OF MARYLAND-DEMH                              |                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------|
| BIRTH NO. <u>M-532</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 72 08582                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                        |                                                                          |                                                                  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Richard Montgomery</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                                                                         | 2. DATE AND HOUR OF DEATH<br><u>9/5/72</u> <u>15:20 P.M.</u>                                                                                                                                                                                                                                                           |                                                                          |                                                                  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>University Hospital</u><br><u>38 Baltimore</u>                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>PACIFIC ST.</u><br>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>718 PACIFIC ST.</u> |                                                                          |                                                                  |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                             | 8. DATE OF BIRTH<br><u>7-8-94</u>                                                                                                                                                                                                                                                                                      | 9. AGE (In years last birthday)<br><u>78</u>                             | 10. Under 1 Yr. Months Days Hours Min.<br>11. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>TEXTILE WORKER</u>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>M.T. VERNON MILLS</u>                                                                                                                                           |                                                                                                                                                                                                                                                                                                                        | 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u>                  |                                                                  |
| 13. FATHER'S NAME<br><u>?</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                                                                         | 14. MOTHER'S MAIDEN NAME<br><u>?</u>                                                                                                                                                                                                                                                                                   |                                                                          |                                                                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 16. SOCIAL SECURITY NO.<br><u>215-07-6558A</u>                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                        | 17. INFORMANT<br><u>Nancy F. Montgomery</u>                              |                                                                  |
| 18. <u>410.9 14250.9</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><br>[This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.]<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>Diabetes Mellitus</u> |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Acute myocardial infarction 7 days</u><br>(B) <u>Pulmonary emboli</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>ASCD</u> |                                                                                                                                                                                                                                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>7 days</u>            |                                                                  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No)                                                |                                                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                |                                                                                                                                                                                                                                                                                                                        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                               |                                                                                                                                                                                                                                                                                                                        | 21F. HOW DID INJURY OCCUR?                                               |                                                                  |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>8/23</u> 19 <u>72</u> to <u>9/5</u> 19 <u>72</u> that (I) <u>we</u> last saw the deceased alive on <u>9/5</u> 19 <u>72</u> and that (I) <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above (I) <u>we</u> (did) (did not) view the body after death.                                                                                                                                                                                  |                      |                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        |                                                                          |                                                                  |
| 23A. SIGNATURE<br><u>Louis S. Dwyer</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        | 23B. DATE SIGNED<br><u>9/5/72</u>                                        |                                                                  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        | 23D. ADDRESS<br><u>3615 Chestnut Ave</u>                                 |                                                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 24B. DATE<br><u>9-9-72</u>                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                        | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Park</u>               |                                                                  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Balt. Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 7 1972</u>                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                        | 25B. NAME OF REGISTRAR<br><u>Richard Montgomery</u>                      |                                                                  |
| 25C. FUNERAL DIRECTOR<br><u>Paul G. Montgomery</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 25D. ADDRESS<br><u>3615 Chestnut Ave</u>                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                        |                                                                          |                                                                  |



# FUNERAL DIRECTOR: IMPORTANT

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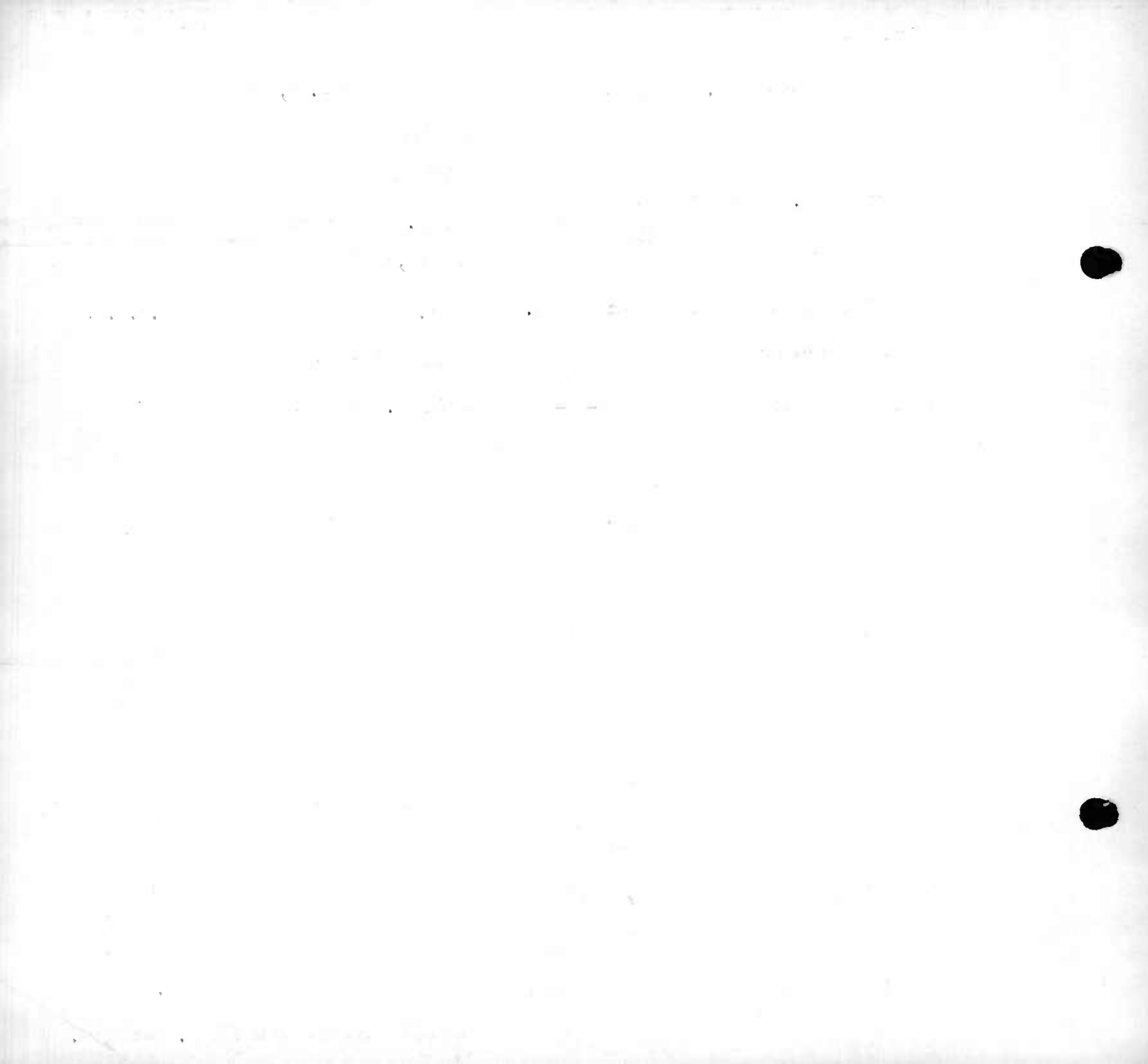
|                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                        |  | REG. NO. <b>72 08583</b>                                                                                                               |  |
| BIRTH NO. <b>H-635</b>                                                                                                                                                                                                                                                                                                  |  | 72 08583                                                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>RICHARD V. HARDEN SR</b>                                                                                                                                                                                                                                                      |  | 2. DATE AND HOUR OF DEATH<br><b>9/2/72 9<sup>am</sup></b>                                                                              |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                  |  | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                    |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44</b>                                                                                                                                                                                                                                       |  | D. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                            |  |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                      |  | 6. RACE<br><b>WHITE</b>                                                                                                                |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                             |  | 8. DATE OF BIRTH<br><b>6/19/03</b>                                                                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SECURITY GUARD</b>                                                                                                                                                                                                    |  | 9. AGE (In years last birthday)<br><b>69</b>                                                                                           |  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>DEF. SECURITY GUARD</b>                                                                                                                                                                                                                                                         |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD</b>                                                                                 |  |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>                                                                                             |  |
| 16. SOCIAL SECURITY NO.<br><b>217-01-9570</b>                                                                                                                                                                                                                                                                           |  | 17. INFORMANT<br><b>Richard V. Harden Jr</b>                                                                                           |  |
| 18. <b>571.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b>                                                                       |  | ADDRESS <b>21205</b><br><b>1018 Guntel Way</b>                                                                                         |  |
| 19. <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>RENAL FAILURE</b>                                                                                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                           |  |
| 19A. DATE OF OPERATION<br><b>9/2/72</b>                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RENAL FAILURE</b>                                                               |  |
| 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                                                                                                                                                                                                  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>NO</b>                                  |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><b>NO</b>                                                                                                                                                                                                                                |  | 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>NO</b>                                                              |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                               |  | 21F. HOW DID INJURY OCCUR?<br><b>NO</b>                                                                                                |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/29/72</b> to <b>9/2/72</b> , that (I) (we) last saw the deceased alive on <b>9/2/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                        |  |
| 23A. SIGNATURE<br><b>Dr. Ruffael</b>                                                                                                                                                                                                                                                                                    |  | 23B. DATE SIGNED<br><b>9/2/72</b>                                                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. RUFFAEL</b>                                                                                                                                                                                                                                                                      |  | 23D. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                               |  | 24B. DATE<br><b>9-7-72</b>                                                                                                             |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>LODGE PARK</b>                                                                                                                                                                                                                                                                 |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE</b>                                                                      |  |
| 25. DATE REC'D BY HEALTH DEPT.<br><b>SEP 7 1972</b>                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br><b>Andrew W. Boston</b>                                                                                      |  |
| 25C. FUNERAL DIRECTOR<br><b>Paul E. [Signature]</b>                                                                                                                                                                                                                                                                     |  | ADDRESS<br><b>3415 Chestnut Ave.</b>                                                                                                   |  |



# FUNERAL DIRECTOR: IMPORTANT

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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 72 08584                                                                                                                                                                                                 |  |
| BIRTH NO. <span style="font-size: 2em;">S-432</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 72 08584                                                                                                                                                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.5em;">August W. Scholtes</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.5em;">Sept. 3, 1972</span>                                                                                                                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><span style="font-size: 1.5em;">43 South Balto. General Hospital</span>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.5em;">Maryland</span><br>B. COUNTY <span style="font-size: 2em;">2402</span> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><span style="font-size: 1.5em;">South Balto. General Hospital</span>                                                                                                                                                                                                                                                                                                                                                                      |  | C. CITY OR TOWN <span style="font-size: 1.5em;">Baltimore</span><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                           |  |
| 5. SEX <span style="font-size: 1.5em;">Male</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 6. RACE <span style="font-size: 1.5em;">White</span>                                                                                                                                                     |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                |  | 8. DATE OF BIRTH <span style="font-size: 1.5em;">March 10, 1893</span>                                                                                                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.5em;">Steam Meter Tester</span>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.5em;">Gas &amp; Electric Co.</span>                                                                                                       |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.5em;">Peter Scholtes</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.5em;">Anna Elizabeth Goebel</span>                                                                                                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.5em;">yes WW 11</span>                                                                                                                                                                                                                                                                                                                                                                                               |  | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.5em;">164-01-4380</span>                                                                                                                            |  |
| 17. INFORMANT<br><span style="font-size: 1.5em;">William E. Scholtes</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS                                                                                                                                                                                                  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br><span style="font-size: 1.5em;">Acute Coronary Occlusion</span><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.5em;">Arteriosclerotic Cardio Vascular Disease</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.5em;">instantaneous</span><br><br><span style="font-size: 1.5em;">years</span>                                                 |  |
| 19. DATE OF OPERATION <span style="font-size: 1.5em;">9-10-72</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                 |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">February</span> 19 <span style="font-size: 1.5em;">70</span> to <span style="font-size: 1.5em;">9-3</span> 19 <span style="font-size: 1.5em;">72</span><br>that (I) (we) lost saw the deceased alive on <span style="font-size: 1.5em;">9-3</span> 19 <span style="font-size: 1.5em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  | 23A. SIGNATURE<br><span style="font-size: 1.5em;">Rolando V. Goody</span><br>DEGREE                                                                                                                      |  |
| 23B. DATE SIGNED<br><span style="font-size: 1.5em;">9-5-72</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.5em;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE<br><span style="font-size: 1.5em;">9/6/72</span>                                                                                                                                               |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.5em;">New Cathedral Cemetery</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.5em;">Baltimore Md.</span>                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.5em;">SEP 7 1972</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.5em;">Audrey W. Hyatt</span>                                                                                                                         |  |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.5em;">Mc Cully Funeral Home</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | ADDRESS<br><span style="font-size: 1.5em;">130 E. Fort Ave.</span>                                                                                                                                       |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                               |          |                                                                                                       |                   |                                                                         |                                 | REG. NO. <b>72 08585</b> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------|---------------------------------|--------------------------|
| W-232 72 08585                                                                                                                                                                                                                                                                                                 |          |                                                                                                       |                   |                                                                         |                                 | STATE OF MARYLAND-DEATH  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                         |          | 2. DATE AND HOUR OF DEATH                                                                             |                   | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                  |                                 |                          |
| Allen J. Westcoat Sr.                                                                                                                                                                                                                                                                                          |          | August 26, 1972 8/25/ M.                                                                              |                   |                                                                         |                                 |                          |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                                                                                                          |          | 5. CITY OR TOWN                                                                                       |                   | 6. INSIDE CITY LIMITS?                                                  |                                 |                          |
| Md. 2544                                                                                                                                                                                                                                                                                                       |          | Baltimore                                                                                             |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |                                 |                          |
| 7. STREET AND NUMBER                                                                                                                                                                                                                                                                                           |          | 8. FATHER'S NAME                                                                                      |                   |                                                                         |                                 |                          |
| 3602 Brooklyn Ave 21225                                                                                                                                                                                                                                                                                        |          | Lester Westcoat                                                                                       |                   |                                                                         |                                 |                          |
| 9. SEX                                                                                                                                                                                                                                                                                                         | 10. RACE | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                           | 12. DATE OF BIRTH | 13. AGE (In years last birthday)                                        | 14. If Under 1 Yr. Months; Days |                          |
| M                                                                                                                                                                                                                                                                                                              | White    | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                         | Nov 6, 1920       | 57                                                                      | If Under 24 Hrs. Hours Min.     |                          |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                     |          | 16. KIND OF BUSINESS OR INDUSTRY                                                                      |                   | 17. BIRTHPLACE (State or foreign country)                               |                                 |                          |
| Retired                                                                                                                                                                                                                                                                                                        |          |                                                                                                       |                   | Md.                                                                     |                                 |                          |
| 18. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                   |          | 19. MOTHER'S MAIDEN NAME                                                                              |                   |                                                                         |                                 |                          |
| U SA                                                                                                                                                                                                                                                                                                           |          | Edith ?                                                                                               |                   |                                                                         |                                 |                          |
| 20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                       |          | 21. SOCIAL SECURITY NO.                                                                               |                   | 22. INFORMANT ADDRESS                                                   |                                 |                          |
| no                                                                                                                                                                                                                                                                                                             |          | 215 03 3452                                                                                           |                   | Allen J. Westcoat Jr 3602 Brooklyn Ave                                  |                                 |                          |
| 23. CAUSE OF DEATH                                                                                                                                                                                                                                                                                             |          |                                                                                                       |                   |                                                                         |                                 |                          |
| 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                     |          |                                                                                                       |                   |                                                                         |                                 |                          |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                               |          |                                                                                                       |                   |                                                                         |                                 |                          |
| 24. ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                          |          |                                                                                                       |                   |                                                                         |                                 |                          |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                      |          |                                                                                                       |                   |                                                                         |                                 |                          |
| 25. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction 1 day                                                                                                                                                                                                                      |          |                                                                                                       |                   |                                                                         |                                 |                          |
| 26. (B) CHRONIC DISEASES DUE TO, OR AS A CONSEQUENCE OF: Coronary Atherosclerosis 3 weeks                                                                                                                                                                                                                      |          |                                                                                                       |                   |                                                                         |                                 |                          |
| 27. (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):                                                                                                                                                                       |          |                                                                                                       |                   |                                                                         |                                 |                          |
| 28. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |          | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                   | 30. AUTOPSY? (Yes or No)                                                |                                 |                          |
| 0                                                                                                                                                                                                                                                                                                              |          |                                                                                                       |                   |                                                                         |                                 |                          |
| 31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                           |          | 32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                   | 33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                 |                          |
| 34. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                       |          | 35. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                   | 36. HOW DID INJURY OCCUR?                                               |                                 |                          |
| 37. I certify that (I) (this hospital) attended the deceased from Aug 2 1972 to Aug 30 1972, that (I) (we) last saw the deceased alive on Aug 28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |          |                                                                                                       |                   |                                                                         |                                 |                          |
| 38. SIGNATURE                                                                                                                                                                                                                                                                                                  |          |                                                                                                       |                   | 39. DATE SIGNED                                                         |                                 |                          |
| Surgeon General                                                                                                                                                                                                                                                                                                |          |                                                                                                       |                   | Aug 30 1972                                                             |                                 |                          |
| 40. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                    |          | 41. ADDRESS                                                                                           |                   |                                                                         |                                 |                          |
|                                                                                                                                                                                                                                                                                                                |          | Medical Center Hammonds Lane Balto 21225                                                              |                   |                                                                         |                                 |                          |
| 42. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                        |          | 43. DATE                                                                                              |                   | 44. NAME of CEMETERY or CREMATORY                                       |                                 |                          |
| Burial                                                                                                                                                                                                                                                                                                         |          | 9/2/72                                                                                                |                   | Glen Haven Cemetery                                                     |                                 |                          |
| 45. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                 |          | 46. NAME OF REGISTRAR                                                                                 |                   | 47. FUNERAL DIRECTOR ADDRESS                                            |                                 |                          |
| SEP 7 1972                                                                                                                                                                                                                                                                                                     |          | Sidney H. Gordon                                                                                      |                   | McLully Funeral Home 237 Patapsco Ave                                   |                                 |                          |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| U-550                                                                                                                                                                                  |  |                                                                                          |  | 72 08586                                                                                                                         |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                              |  | 72 08586                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                              |  |                                                                                          |  | 72 08586                                                                                                                         |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                              |  | 72 08586                                                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                 |  |                                                                                          |  | 2. DATE AND HOUR OF DEATH                                                                                                        |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                    |  |
| <p><u>Ethel Wyman</u></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>00 2720 East Northern Parkway</u></p> |  |                                                                                          |  | <p><u>Sept. 3, 1972</u></p> <p><u>7:00 A.M.</u></p>                                                                              |  | <p><u>Maryland</u></p> <p>C. CITY OR TOWN</p> <p><u>Baltimore</u></p> <p>E. STREET AND NUMBER</p> <p><u>2720 East Northern Parkway</u></p>                                                                                                                                                    |  | <p>D. INSIDE CITY LIMITS?</p> <p>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> |  |
| 5. SEX                                                                                                                                                                                 |  | 6. RACE                                                                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                       |  | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                              |  | 9. AGE (In years last birthday)                                                                          |  |
| <u>Female</u>                                                                                                                                                                          |  | <u>White</u>                                                                             |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                    |  | <u>4/25/07</u>                                                                                                                                                                                                                                                                                |  | <u>65</u>                                                                                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                            |  |                                                                                          |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?                                                                             |  |
| <u>Housewife</u>                                                                                                                                                                       |  |                                                                                          |  | <u>Homemaker</u>                                                                                                                 |  | <u>Chicago, Ill.</u>                                                                                                                                                                                                                                                                          |  | <u>U.S.A.</u>                                                                                            |  |
| 13. FATHER'S NAME                                                                                                                                                                      |  |                                                                                          |  | 14. MOTHER'S MAIDEN NAME                                                                                                         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                      |  |                                                                                                          |  |
| <u>Charles Stevens</u>                                                                                                                                                                 |  |                                                                                          |  | <u>Margaret Clancy</u>                                                                                                           |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                       |  |                                                                                                          |  |
| <u>No</u>                                                                                                                                                                              |  |                                                                                          |  | <u>220-46-4680</u>                                                                                                               |  | 17. INFORMANT                                                                                                                                                                                                                                                                                 |  |                                                                                                          |  |
| <u>410.9</u>                                                                                                                                                                           |  |                                                                                          |  | <u>I</u>                                                                                                                         |  | 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                            |  |                                                                                                          |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                         |  |                                                                                          |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                              |  |                                                                                                                                                                                                                                                                                               |  |                                                                                                          |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                             |  |                                                                                          |  | <u>Acute Myocardial Infarction</u>                                                                                               |  |                                                                                                                                                                                                                                                                                               |  |                                                                                                          |  |
| ANTECEDENT CAUSES                                                                                                                                                                      |  |                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |                                                                                                                                                                                                                                                                                               |  |                                                                                                          |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                              |  |                                                                                          |  | <u>Arteriosclerotic Heart Disease</u>                                                                                            |  |                                                                                                                                                                                                                                                                                               |  |                                                                                                          |  |
| (C) _____                                                                                                                                                                              |  |                                                                                          |  | (D) _____                                                                                                                        |  |                                                                                                                                                                                                                                                                                               |  |                                                                                                          |  |
| II                                                                                                                                                                                     |  |                                                                                          |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |                                                                                                                                                                                                                                                                                               |  |                                                                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                                        |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                          |  |                                                                                                          |  |
| <u>0</u>                                                                                                                                                                               |  | <u>0</u>                                                                                 |  | <u>0</u>                                                                                                                         |  | <u>0</u>                                                                                                                                                                                                                                                                                      |  |                                                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR?                                                                                                     |  | (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                   |  |                                                                                                          |  |
| <u>0</u>                                                                                                                                                                               |  | <u>0</u>                                                                                 |  | <u>0</u>                                                                                                                         |  | <u>0</u>                                                                                                                                                                                                                                                                                      |  |                                                                                                          |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                          |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                       |  | 22. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                          |  |
| <u>0</u>                                                                                                                                                                               |  | <u>0</u>                                                                                 |  | <u>0</u>                                                                                                                         |  | <u>0</u>                                                                                                                                                                                                                                                                                      |  |                                                                                                          |  |
| 23A. SIGNATURE                                                                                                                                                                         |  |                                                                                          |  | 23B. DATE SIGNED                                                                                                                 |  | 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                  |  | 23D. ADDRESS                                                                                             |  |
| <u>S. Russo, M.D.</u>                                                                                                                                                                  |  |                                                                                          |  | <u>9/5/72</u>                                                                                                                    |  | <u>S. Russo, M.D.</u>                                                                                                                                                                                                                                                                         |  | <u>5122 Harford Rd. Balto. Md.</u>                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                               |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY                                                                                               |  | 24D. LOCATION (City, town, or county)                                                                                                                                                                                                                                                         |  | (State)                                                                                                  |  |
| <u>Burial</u>                                                                                                                                                                          |  | <u>9/7/72</u>                                                                            |  | <u>Gardens Of Faith Cemetery</u>                                                                                                 |  | <u>Overlea</u>                                                                                                                                                                                                                                                                                |  | <u>Baltimore Md.</u>                                                                                     |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                        |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                                                            |  | ADDRESS                                                                                                                                                                                                                                                                                       |  | 21236                                                                                                    |  |
| <u>SEP 7 1972</u>                                                                                                                                                                      |  | <u>L. J. Russo</u>                                                                       |  | <u>L. J. Russo</u>                                                                                                               |  | <u>7401 Belair Rd. Balto.</u>                                                                                                                                                                                                                                                                 |  | <u>21236</u>                                                                                             |  |



S-300

72 08587

STATE OF MARYLAND - DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08587

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>D. RONNIE SCOTT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Hour M.                                                              |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>43 SOUTH BALTO. GENERAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 1, 1972 5:00 P.</b>                                                                                           |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7. RACE<br><b>Negro</b>                                                                                                                                                      |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2543</b>                                      |  |
| 9. DATE OF BIRTH<br><b>7/23/63</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10. AGE (In years last birthday) <b>9</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                                                          |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                   |  |
| 13. FATHER'S NAME<br><b>Howard Scott</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><b>Shirley Butler</b>                                                                                                                            |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                                                                                                                              |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 18. SOCIAL SECURITY NO.                                                                                                                                                      |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Multiple Injuries</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | 20. DATE OF OPERATION<br><b>2</b>                                                                                                                                            |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>                                                                     |  |
| 23. WHERE DID INJURY OCCUR?<br><b>2200 Blk. Russell Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 24. HOW DID INJURY OCCUR?<br><b>Pedestrian struck by car</b>                                                                                                                 |  |
| 25. TIME (Month) (Day) (Year) (Hour) (Approx.)<br><b>9-1-72 4:55 P.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                             |  |
| 27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                      |  |                                                                                                                                                                              |  |
| 28. ACTUAL SIGNATURE<br><b>Peter Lipkovic, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 29. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 30. DATE REC'D BY HEALTH DEPT.<br><b>SEP 7 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 31. NAME OF REGISTRAR<br><b>Shirley Butler</b>                                                                                                                               |  |
| 32. FUNERAL DIRECTOR<br><b>Marshall W. Jones</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 33. ADDRESS<br><b>1735 Harford Ave. 21213</b>                                                                                                                                |  |
| 34. DATE OF BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 35. DATE<br><b>9/6/72</b>                                                                                                                                                    |  |
| 36. NAME OF CEMETERY or CREMATORY<br><b>St Rest</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 37. LOCATION (City, town, or county) (State)<br><b>Hanover Md</b>                                                                                                            |  |

✓

James Scott  
James Butler  
James Butler

more

7/2/13  
James Butler  
James Butler

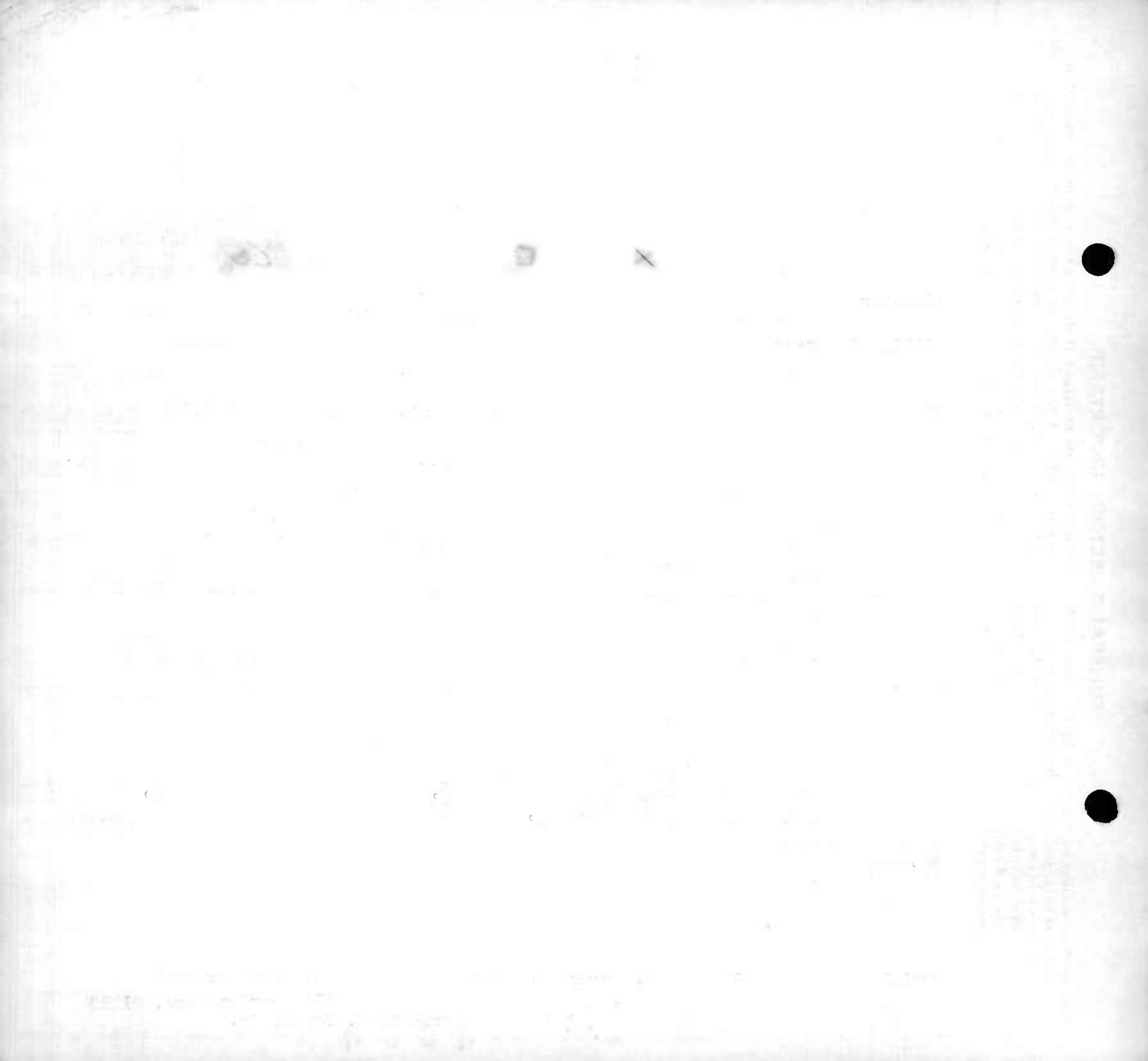
James Butler

James Butler

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                             |                                                                    |                                                                                                                                        |                                               |                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| 1-521                                                                                                                                                                                                                                                                                                                                               |                     | 72 08588                                                                                                                                                    |                                                                    | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                       |                                               | REG. NO. 72 08588                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |                                                                    | STATE OF MARYLAND-DHMH                                                                                                                 |                                               |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LUNSFORD ANNIE</b>                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |                                                                    | 2. DATE AND HOUR OF DEATH<br><b>12:25AM 9-5-72 12:00 A.M.</b>                                                                          |                                               |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b> |                                               |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>39 Provident Hosp Inc</b><br><b>2304 CALVERTON HT AVE</b><br><b>Baltimore, MD.</b>                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                                                    | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                    |                                               | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><b>2304 CALVERTON HT AVE</b>                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |                                                                    |                                                                                                                                        |                                               |                                                                                               |  |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                  | 6. RACE<br><b>B</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-9-1912</b>                                | 9. AGE (In years last birthday)<br><b>60</b>                                                                                           | 10. Under 1 Yr. Months Days                   | 11. Under 24 Hrs. Hours Min.                                                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Minister</b>                                                                                                                                                                                                                                      |                     |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, MD.</b> |                                                                                                                                        | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |                                                                                               |  |
| 13. FATHER'S NAME<br><b>Willie Wilkerson</b>                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Wilkerson</b> Cousin                |                                                                                                                                        |                                               |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                               |                     |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>220-18-8844</b>                      |                                                                                                                                        | 17. INFORMANT<br><b>MR. FRED J. LUNSFORD</b>  |                                                                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Metastatic Ca of lung</b><br><b>Respiratory distress</b><br><b>pleural effusion</b><br><b>Ca of heart, COPD</b>                            |                     |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3-6 MO.</b>     |                                                                                                                                        |                                               |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                                                    |                                                                                                                                        |                                               |                                                                                               |  |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                    | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                |                                               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                               |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                               |                                               |                                                                                               |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX)                                                                                                                                                                                                                                                                                         |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                    | 21F. HOW DID INJURY OCCUR?                                                                                                             |                                               |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 15, 1972</b> to <b>SEPTEMBER 5, 1972</b> that (I) (we) last saw the deceased alive on <b>SEPTEMBER 5, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                             |                                                                    |                                                                                                                                        |                                               |                                                                                               |  |
| 23A. SIGNATURE<br><b>Willie Brooks, M.D.</b> DEGREE                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |                                                                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>        |                                               | 23B. DATE SIGNED<br><b>9-5-72</b>                                                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Willie Brooks, M.D.</b> DEGREE                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                             |                                                                    | 23D. ADDRESS<br><b>Provident Hospital</b><br><b>Baltimore, MD.</b>                                                                     |                                               |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                           |                     | 24B. DATE<br><b>9-8-1972</b>                                                                                                                                |                                                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Auburn Cemetery</b>                                                                       |                                               | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 7 1972</b>                                                                                                                                                                                                                                                                                                |                     | 25B. NAME OF REGISTRAR<br><b>Shirley Houston</b>                                                                                                            |                                                                    | 25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 41218</b><br><b>Marshall W. Jones, Jr.</b>                                                  |                                               |                                                                                               |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                               |                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 72 08589                                                                                                                                                                                                                                                                                              |              | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                    |                             | REG. NO. 72 08589                                                                             |                                                            |
| <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                           |              |                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                               |                                                            |
| BIRTH NO.                                                                                                                                                                                                                                                                                             |              | STATE OF MARYLAND-DHMH                                                                                                                                                                                                                                                                                                              |                             |                                                                                               |                                                            |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                |              | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                                                                                                                           |                             |                                                                                               |                                                            |
| MATTHEW J. RUPPEL                                                                                                                                                                                                                                                                                     |              | 9-6-1972 11:45 P.M.                                                                                                                                                                                                                                                                                                                 |                             |                                                                                               |                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                                                                                                                               |                             |                                                                                               |                                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>37                                                                                                                                                                                                                                                            |              | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>MERCY HOSPITAL                                                                                                                                                                                                                                              |                             | A. STATE<br>MARYLAND                                                                          |                                                            |
|                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                     |                             | B. COUNTY<br>BALTIMORE                                                                        |                                                            |
|                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                     |                             | C. CITY OR TOWN<br>BALTIMORE                                                                  |                                                            |
|                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                     |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                            |
|                                                                                                                                                                                                                                                                                                       |              | E. STREET AND NUMBER<br>628 S. FAGLEY ST.                                                                                                                                                                                                                                                                                           |                             |                                                                                               |                                                            |
| 5. SEX<br>M                                                                                                                                                                                                                                                                                           | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                    | 8. DATE OF BIRTH<br>5.13.86 | 9. AGE (In years last birthday)<br>86                                                         | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired                                                                                                                                                                                                |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Pipe fitter                                                                                                                                                                                                                                                                                    |                             | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                              |                                                            |
| 13. FATHER'S NAME<br>CONRAD RUPPEL                                                                                                                                                                                                                                                                    |              | 14. MOTHER'S MAIDEN NAME<br>MARGARET                                                                                                                                                                                                                                                                                                |                             | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                           |                                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                              |              | 16. SOCIAL SECURITY NO.<br>213-07-0971                                                                                                                                                                                                                                                                                              |                             | 17. INFORMANT<br>Andrew Ruppalt                                                               |                                                            |
|                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                     |                             | ADDRESS<br>632 S. Fagley Street                                                               |                                                            |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                 |              | 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                  |                             |                                                                                               |                                                            |
|                                                                                                                                                                                                                                                                                                       |              | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                             |                                                                                               |                                                            |
|                                                                                                                                                                                                                                                                                                       |              | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>UREMIA                                                                                                                                                                                                                                                                    |                             |                                                                                               |                                                            |
|                                                                                                                                                                                                                                                                                                       |              | (B) OBSTRUCTIVE UROPATHY<br>DUE TO, OR AS A CONSEQUENCE OF:<br>CARCINOMA OF PROSTATE                                                                                                                                                                                                                                                |                             |                                                                                               |                                                            |
|                                                                                                                                                                                                                                                                                                       |              | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                              |                             |                                                                                               |                                                            |
| 19A. DATE OF OPERATION<br>9                                                                                                                                                                                                                                                                           |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                    |                             | 20A. AUTOPSY? (Yes or No)<br>No                                                               |                                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                 |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                            |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                            |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                             |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                           |                             | 21F. HOW DID INJURY OCCUR?                                                                    |                                                            |
| 22. I certify that (1) (this hospital) attended the deceased from 9:5 1972 to 9:6 1972, that (1) (we) last saw the deceased alive on 9:6 1972 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |              |                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                               |                                                            |
| 23A. SIGNATURE<br>Kenneth R. Warrick M.D.                                                                                                                                                                                                                                                             |              | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                                                                                                                                     |                             | 23B. DATE SIGNED<br>9/6/72                                                                    |                                                            |
| 23C. PHYSICIAN'S NAME (Type)<br>KENNETH WARRICK M.D.                                                                                                                                                                                                                                                  |              | 23D. ADDRESS<br>301 ST. PAUL PLACE                                                                                                                                                                                                                                                                                                  |                             |                                                                                               |                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                    |              | 24B. DATE<br>9-9-1972                                                                                                                                                                                                                                                                                                               |                             | 24C. NAME OF CEMETERY or CREMATORY<br>Sacred Heart                                            |                                                            |
|                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                                                                                                                                                                                                     |                             | 24D. LOCATION (City, town, or county) (State)<br>Baltimore County, Maryland                   |                                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 7 1972                                                                                                                                                                                                                                                         |              | 25B. NAME OF REGISTRAR<br>Audrey S. Boston                                                                                                                                                                                                                                                                                          |                             | 25C. FUNERAL DIRECTOR<br>Lilly & Zeiler Inc. 700 S. Conkling St.                              |                                                            |



Noted

Pipe Riser

Bellevue, Maryland

213-07-0071 Andrew Rupinski 632 S. Valley Street

Ho

Butel

2-2-1973

Garrod House

Bellevue County, Maryland

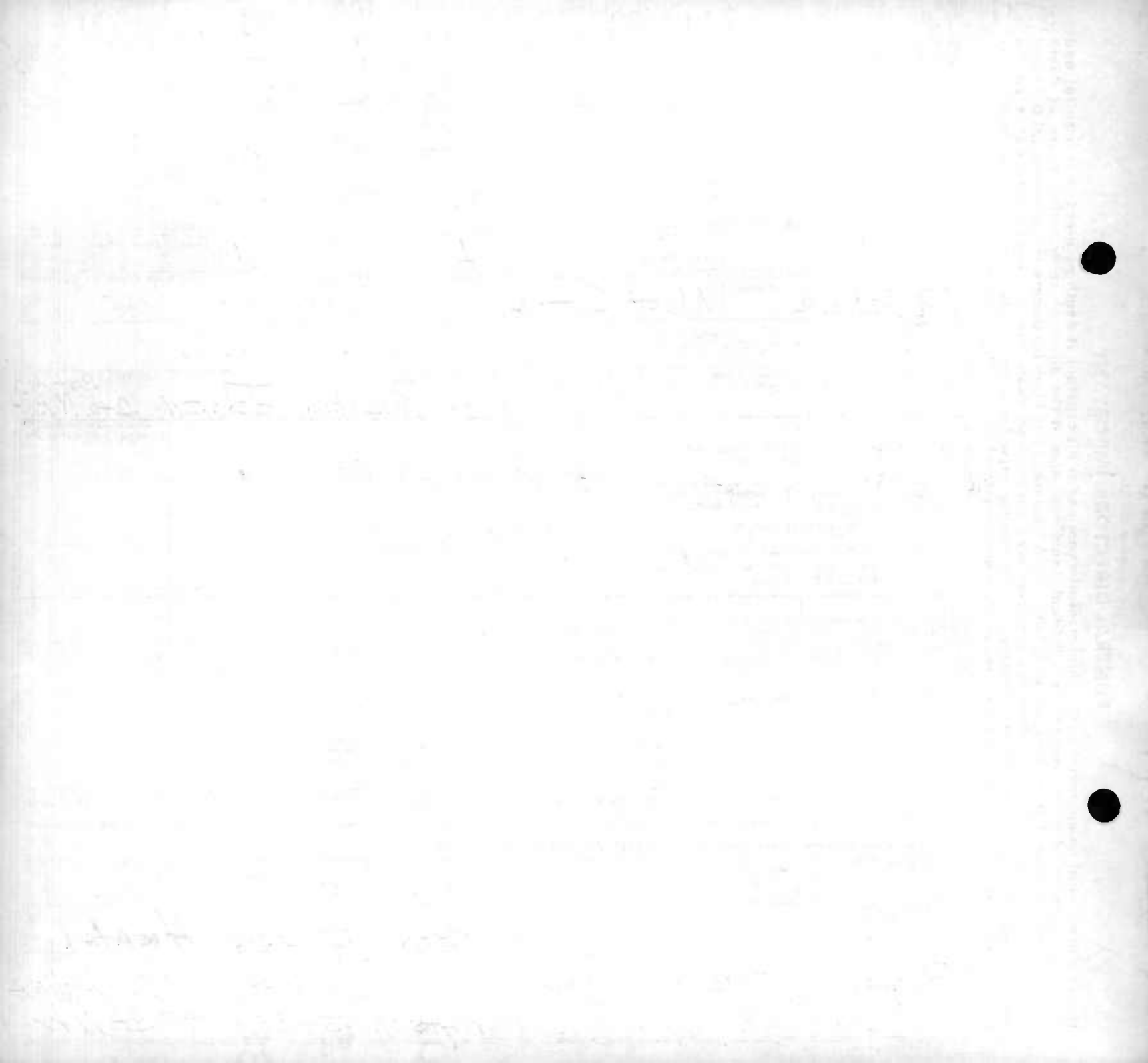
213-07-0071 Ralph A. Sailer Inc. 700 S. Conklin St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

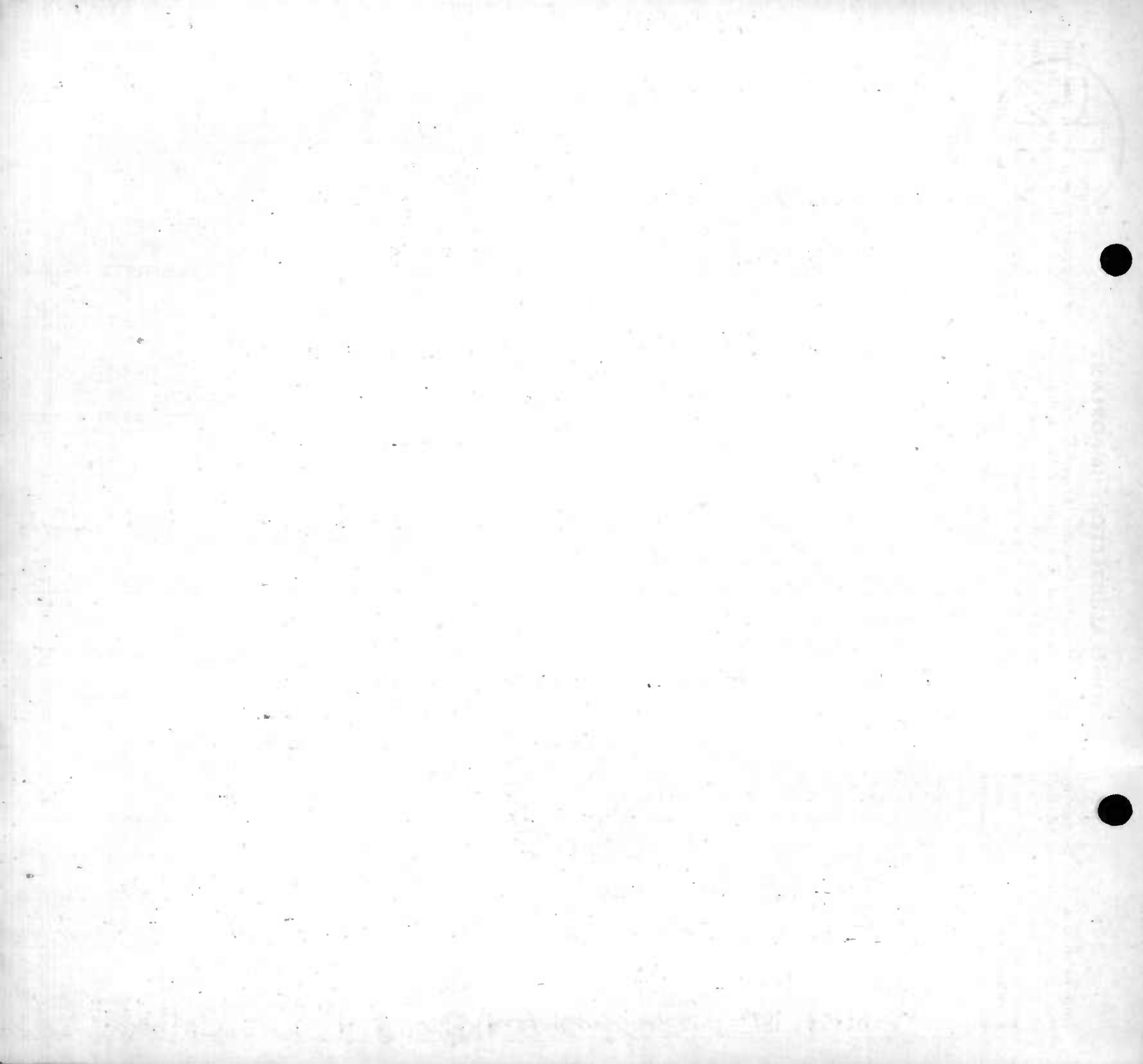
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                          |                                                      | 72 08590                                                                                                                                                                                                                                                                                                          |                                                                           | REG. NO. 72 08590                                                    |                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                          |                                                      | STATE OF MARYLAND-DEMH                                                                                                                                                                                                                                                                                            |                                                                           |                                                                      |                                         |
| 1. NAME OF DECEASED<br>(Type or Print) <b>WADE E. JOHNSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                          |                                                      | 2. DATE AND HOUR OF DEATH<br><b>9/2/72 8:50 P.M.</b>                                                                                                                                                                                                                                                              |                                                                           |                                                                      |                                         |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>4 BON SECOURS HOSPITAL</b>                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                          |                                                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALT.</b> C. CITY OR TOWN <b>BALT.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>240 N. PAYSON ST. MD 21225</b> |                                                                           |                                                                      |                                         |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. RACE <b>B</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1/7/11</b>                       |                                                                                                                                                                                                                                                                                                                   | 9. AGE (In years last birthday) <b>61</b>                                 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.              |                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                          | 10B. KIND OF BUSINESS OR INDUSTRY <b>Meat Cutter</b> |                                                                                                                                                                                                                                                                                                                   | 11. BIRTHPLACE (State or foreign country) <b>S. CAROLINA</b>              |                                                                      | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |
| 13. FATHER'S NAME <b>THOMAS STEVENSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                          |                                                      | 14. MOTHER'S MAIDEN NAME <b>MOLLIE JOHNSON</b>                                                                                                                                                                                                                                                                    |                                                                           |                                                                      |                                         |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                          | 16. SOCIAL SECURITY NO. <b>250-03-6562</b>           |                                                                                                                                                                                                                                                                                                                   | 17. INFORMANT <b>Rudolph Johnson</b> ADDRESS <b>Balt MD 240 N. Payson</b> |                                                                      |                                         |
| 18. <b>5-6-9-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>HEPATIC COMA</b> DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>PROBABLY G.I. BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>DAYS</b> |                  |                                                                                                                                                          |                                                      |                                                                                                                                                                                                                                                                                                                   |                                                                           |                                                                      |                                         |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>ACUTE CORONARY INSUFFICIENCY</b>                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                          |                                                      |                                                                                                                                                                                                                                                                                                                   |                                                                           |                                                                      |                                         |
| 19A. DATE OF OPERATION <b>9/2/72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                      | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                     |                                                                           | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                         |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                          |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                          |                                                                           |                                                                      |                                         |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                        |                                                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                        |                                                                           |                                                                      |                                         |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/2/72</b> to <b>9/2/72</b> that (I) (we) last saw the deceased alive on <b>9/2/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                    |                  |                                                                                                                                                          |                                                      |                                                                                                                                                                                                                                                                                                                   |                                                                           |                                                                      |                                         |
| 23A. SIGNATURE <b>Chaihan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                          |                                                      | 23B. DATE SIGNED <b>9/2/72</b>                                                                                                                                                                                                                                                                                    |                                                                           |                                                                      |                                         |
| 23C. PHYSICIAN'S NAME (Type) <b>CHAIHAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                          |                                                      | 23D. ADDRESS <b>BON SECOURS HOSPITAL</b>                                                                                                                                                                                                                                                                          |                                                                           |                                                                      |                                         |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 24B. DATE <b>9/7/72</b>                                                                                                                                  |                                                      | 24C. NAME OF CEMETERY OR CREMATORY <b>Church</b>                                                                                                                                                                                                                                                                  |                                                                           | 24D. LOCATION (City, town, or county) (State) <b>CONWAY. S.C.</b>    |                                         |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 25B. NAME OF REGISTRAR <b>Andrew Watson</b>                                                                                                              |                                                      | 25C. FUNERAL DIRECTOR <b>3435-17th St. N.W.</b>                                                                                                                                                                                                                                                                   |                                                                           | ADDRESS                                                              |                                         |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                               |  |                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |  |                             |  | REG. NO.                                                                                      |  |                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|-----------------------------------------------------------------------------------------------|--|------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                  |  |                    |  | 2. DATE AND HOUR OF DEATH                                                                                                                                   |  |                             |  | STATE OF MARYLAND-DEMH                                                                        |  |                                          |  |
| Ruth H. Powell                                                                                                                                                                                                                                                                                                          |  |                    |  | 9/5/1972                                                                                                                                                    |  |                             |  | 11:30 A.M.                                                                                    |  |                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                  |  |                    |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                                                                       |  |                             |  |                                                                                               |  |                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                            |  |                    |  | A. STATE<br>Md.                                                                                                                                             |  |                             |  | B. COUNTY<br>1203                                                                             |  |                                          |  |
| 342 E. 25th Street                                                                                                                                                                                                                                                                                                      |  |                    |  | C. CITY OR TOWN<br>Balto                                                                                                                                    |  |                             |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                          |  |
| E. STREET AND NUMBER<br>342 E. 25th St.                                                                                                                                                                                                                                                                                 |  |                    |  |                                                                                                                                                             |  |                             |  |                                                                                               |  |                                          |  |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                             |  | 6. RACE<br>Negroid |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>10-4-19 |  | 9. AGE (In years lost birthday)<br>53 52                                                      |  | If Under 1 Yr. Months: Days: Hours: Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                             |  |                    |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  |                             |  | 11. BIRTHPLACE (State or foreign country)<br>Md.                                              |  |                                          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                  |  |                    |  | 13. FATHER'S NAME<br>HARRY STEPNEY                                                                                                                          |  |                             |  | 14. MOTHER'S MAIDEN NAME<br>LEATHEA NORRIS                                                    |  |                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                |  |                    |  | 16. SOCIAL SECURITY NO.<br>220-18-3492                                                                                                                      |  |                             |  | 17. INFORMANT<br>CARL POWELL SAME                                                             |  |                                          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>174X I<br>Wide spread metastatic Carcinoma of breast                                                               |  |                    |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Carcinoma, Lt. breast                                                                                |  |                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr.<br>20 months                            |  |                                          |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                          |  |                    |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                                                                                                  |  |                             |  |                                                                                               |  |                                          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                  |  |                    |  |                                                                                                                                                             |  |                             |  |                                                                                               |  |                                          |  |
| 19A. DATE OF OPERATION<br>Jan. 6, 1971                                                                                                                                                                                                                                                                                  |  |                    |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Lt. breast Carcinoma                                                                                    |  |                             |  | 20A. AUTOPSY? (Yes or No)<br>No                                                               |  |                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                   |  |                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  |                             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |                                          |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                               |  |                    |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  |                             |  | 21F. HOW DID INJURY OCCUR?                                                                    |  |                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 15 1971 to August 23 1972, that (I) (we) last saw the deceased alive on August 23 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                    |  |                                                                                                                                                             |  |                             |  |                                                                                               |  |                                          |  |
| 23A. SIGNATURE<br>John Lee MD                                                                                                                                                                                                                                                                                           |  |                    |  | 23B. DATE SIGNED<br>9/5/72                                                                                                                                  |  |                             |  |                                                                                               |  |                                          |  |
| 23C. PHYSICIAN'S NAME (Type)<br>JAE M. LEE MD                                                                                                                                                                                                                                                                           |  |                    |  | 23D. ADDRESS<br>Johns Hopkins Hospital, Baltimore, Md.                                                                                                      |  |                             |  |                                                                                               |  |                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                      |  |                    |  | 24B. DATE<br>9-9-72                                                                                                                                         |  |                             |  | 24C. NAME OF CEMETERY or CREMATORY<br>St. Thomas Cem.                                         |  |                                          |  |
| 24D. LOCATION<br>Balto. Md.                                                                                                                                                                                                                                                                                             |  |                    |  | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 7 1972                                                                                                               |  |                             |  | 25B. NAME OF REGISTRAR<br>Audrey Weston                                                       |  |                                          |  |
| 25C. FUNERAL DIRECTOR<br>N. Bailey                                                                                                                                                                                                                                                                                      |  |                    |  | 25D. ADDRESS<br>1348 Calhoun St.                                                                                                                            |  |                             |  |                                                                                               |  |                                          |  |



S-220

72 08592 BALTIMORE CITY HEALTH DEPARTMENT

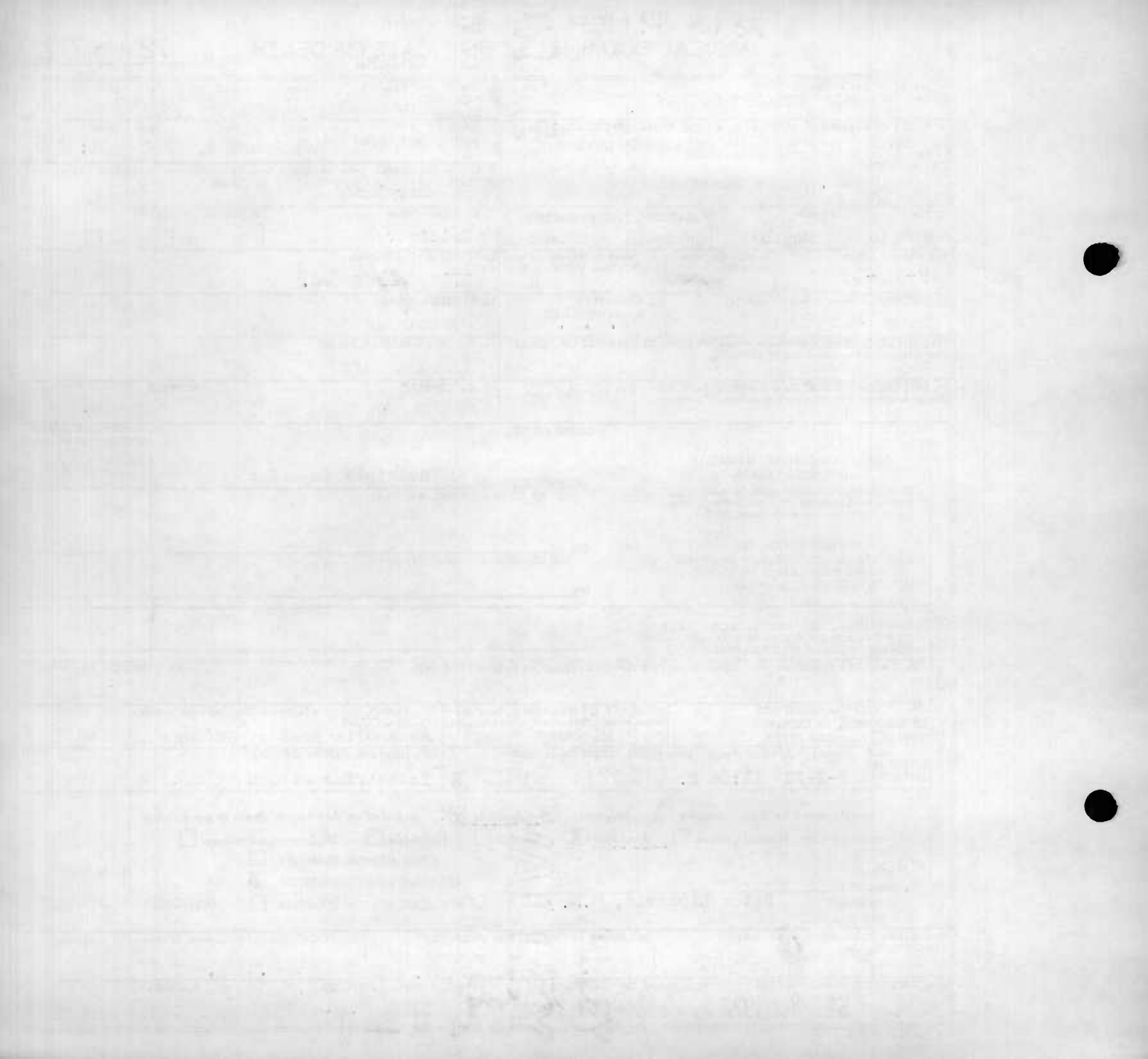
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08592

BIRTH NO.

STATE OF MARYLAND-DEMD

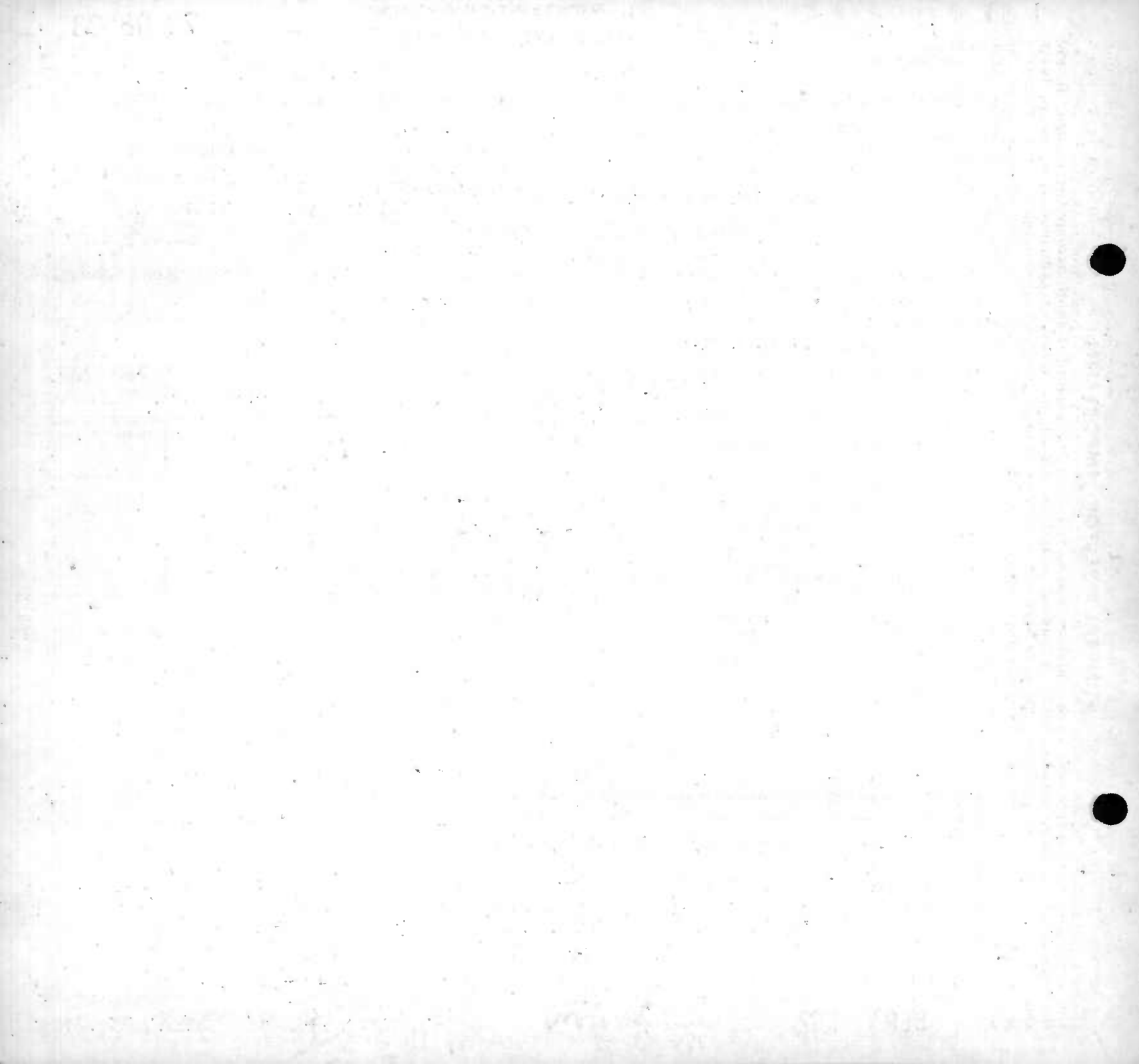
|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) ANN DOLORES SYKES                                                                                                                                                                                                                                                                                                                                                      |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> September 2, 1972 M.                                                                                     |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>40 St. Agnes Hospital                                                                                                                                                                                                                                                                                       |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>September 2, 1972 11:30 P. M.                                                                                                                                |  |
| 6. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                              |  | 7. RACE<br>Negro                                                                                                                                                                                          |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                                                              |  |
| 9. DATE OF BIRTH<br>9-17-35                                                                                                                                                                                                                                                                                                                                                                                   |  | 10. AGE (In years lost birthday) 36<br>If Under 1 Yr. II Under 24 Hrs.<br>Months Days Hours Min.                                                                                                          |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF<br>WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                 |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME<br>Helen Husen                                                                                                                                                                   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                 |  | 17. SOCIAL SECURITY NO.                                                                                                                                                                                   |  |
| 18. INFORMANT<br>James Webster                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br>905 Stricker St.                                                                                                                                                                               |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>E814.17<br>Multiple injuries                                                                                                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                              |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                    |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                       |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                          |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Highway                                                                                                       |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>Annapolis Road at Hoffman Avenue                                                                                                                                                                                                                                                                                                  |  | 22F. HOW DID INJURY OCCUR?<br>Pedestrian struck by auto 5300                                                                                                                                              |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br>9-2-72 11:08 P. m.                                                                                                                                                                                                                                                                                                                               |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                      |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                                                           |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Peter Lipkovic, M.D.                                                                                                                                                                                                                                                                                                                                            |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED<br>September 3, 1972 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br>9-9-72                                                                                                                                                                                       |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Mt. Calvary Cem.                                                                                                                                                                                                                                                                                                                                                        |  | 24D. LOCATION (City, town, or county) (State)<br>Balto., Md.                                                                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 7 1972                                                                                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR<br>Audrey M. Weston                                                                                                                                                                |  |
| 25C. FUNERAL DIRECTOR<br>V. Bailey                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS<br>Kelson F.H. 1348 Calhoun Street                                                                                                                                                                |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                             |  |                                                                                               |  |                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| J-552                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              | 72 08593                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                              |  | REG. NO. 72 08593                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                             |  | STATE OF MARYLAND - DEMO                                                                      |  |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH                                                                     |  |                                                                      |  |
| Grace Jennings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                             |  | Sept. 6, 1972                                                                                 |  |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)         |  |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>90 Long Green Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                             |  | A. STATE<br>Maryland                                                                          |  |                                                                      |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |  | B. COUNTY                                                                                     |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                             |  | C. CITY OR TOWN<br>Baltimore                                                                  |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                             |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              |                                                                                                                                                             |  | E. STREET AND NUMBER<br>5512 Roland Avenue 21210                                              |  |                                                                      |  |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>12-6-1886                                                                 |  | 9. AGE (in years last birthday)<br>85                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None                                                                                                                                                                                                                                                                                                                                                                                                                       |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>None                                                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                         |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                  |  |
| 13. FATHER'S NAME<br>Joseph R. Jennings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br>Alice Toland                                                      |  |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                         |              |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br>220-44-4473                                                        |  | 17. INFORMANT<br>Mr. Frank L. Jennings, Jr. Lutherville, Md.         |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>436.9 I<br>CAUSE OF DEATH<br>C. V. A.<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Arteriosclerosis<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>Anemia<br>(C) _____ |              |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |                                                                      |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |  |                                                                                               |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br>No                                                               |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                     |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |  |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                    |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 7/22 1972 to Sept 6 1972, that (I) (we) last saw the deceased alive on Sept 5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                             |              |                                                                                                                                                             |  |                                                                                               |  |                                                                      |  |
| 23A. SIGNATURE<br>William G. Helfrich M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                             |  | 23B. DATE SIGNED<br>7 Sept 72                                                                 |  | 23C. PHYSICIAN'S NAME (Type)<br>William G. Helfrich M.D.             |  |
| 23D. ADDRESS<br>5006 Roland Avenue 21210                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                             |  | 23E. MED. DIRECTOR<br>H. W. Jenkins & Sons Co.                                                |  | 23F. ADDRESS<br>4905 York Road Balto., Md. 21212                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              | 24B. DATE                                                                                                                                                   |  | 24C. NAME of CEMETERY or CREMATORY                                                            |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              | 9-8-72                                                                                                                                                      |  | Greenmount                                                                                    |  | Baltimore, Md.                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              | 25B. NAME OF REGISTRAR                                                                                                                                      |  | 25C. FUNERAL DIRECTOR                                                                         |  | 25D. ADDRESS                                                         |  |
| SEP 7 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              | Andrew Johnson                                                                                                                                              |  | H. W. Jenkins & Sons Co.                                                                      |  | 4905 York Road Balto., Md. 21212                                     |  |





1

72 08594

STATE OF MARYLAND - DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT

W-340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08594

BIRTH NO.

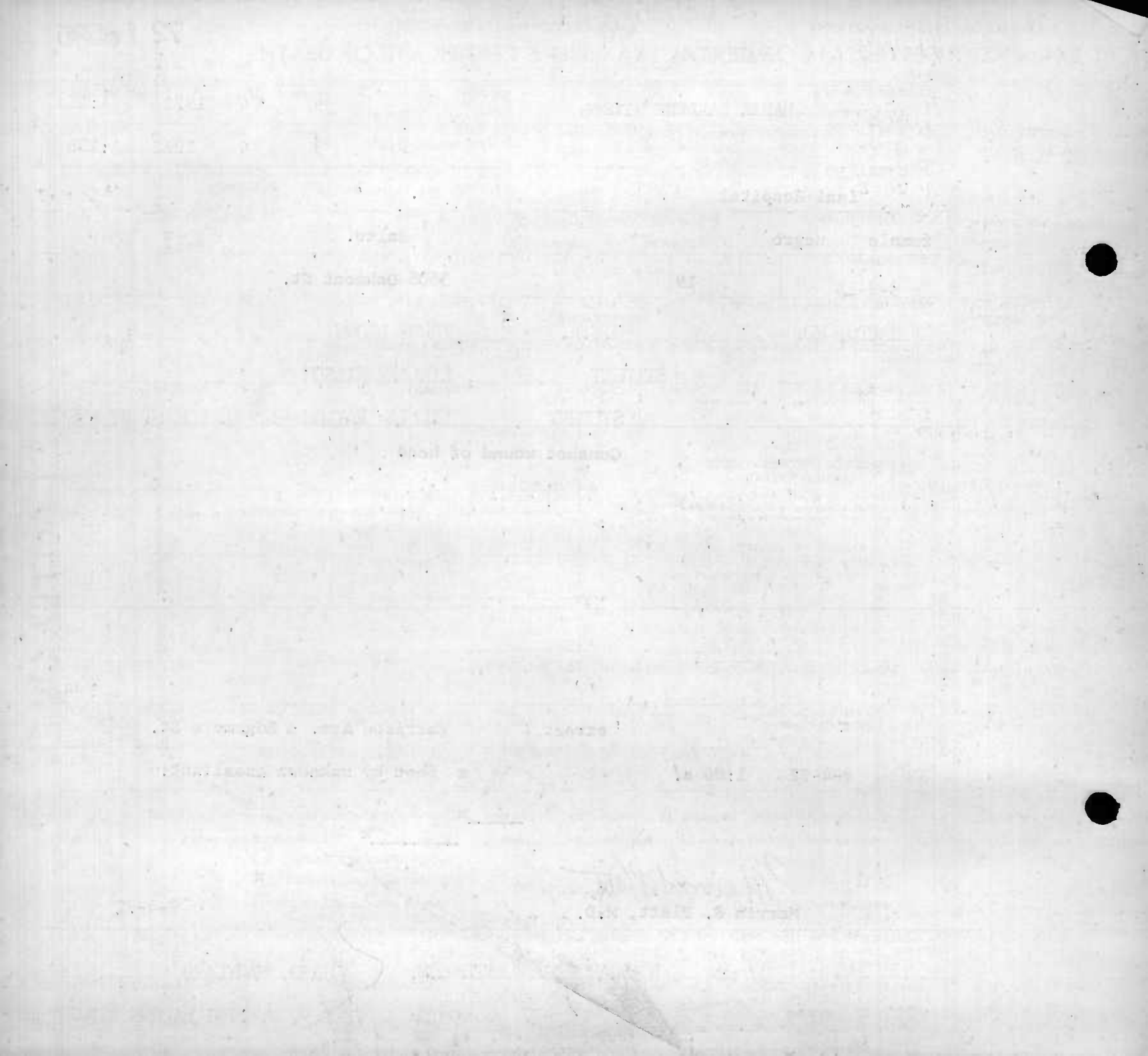
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>E. WILLIAM WHEATLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>4 + 95 UNION MEMORIAL HOSPITAL (DOA)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 5, 1972 8:15 A.M.</b>                                                                        |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>901</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 6. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7. RACE <b>White</b> | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH <b>8-26-1951</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 10. AGE (In years, last birthday) <b>21</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                                       |  |
| 11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                     |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      | 14B. KIND OF BUSINESS OR INDUSTRY <b>Education</b>                                                                                                          |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 17. SOCIAL SECURITY NO. <b>213-52-9601</b>                                                                                                                  |  |
| 18. INFORMANT <b>Mr. John E. Wheatley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | ADDRESS <b>Same</b>                                                                                                                                         |  |
| 19. CAUSE OF DEATH<br><b>E980.12</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| 20A. DATE OF OPERATION <b>9-5-72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unknown</b>                                                     |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>9-5-72 Unknown m.</b>                                                                          |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 22F. HOW DID INJURY OCCUR? <b>Subject ingested overdose of meprobamate</b>                                                                                  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/6/72</b> |                      |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 24B. DATE <b>9-9-72</b>                                                                                                                                     |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>                                                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 25B. NAME OF REGISTRAR <b>H. W. Jenkins &amp; Sons Co.</b>                                                                                                  |  |
| 25C. FUNERAL DIRECTOR <b>4905 York Road Balto., Md. 21212</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 25D. ADDRESS                                                                                                                                                |  |

VS 151-REV. 1/1/68

9-19-1972 - Letter from the Office of the Chief Medical Examiner,  
Peter Lipkovic, M.D., Assistant Medical Examiner

HRS

| STATE OF MARYLAND - DEPT. OF HEALTH<br>BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                       |  |  |  | 72 08595                                                                                                                                  |  |                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | REG. NO.                                                                                                                                  |  |                                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARIE DARLENE WILSON</b><br>( <b>DARLENE</b> )                                                                                                                                                                                                                                                                                                                      |  |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month 9 Day 4 Year 1972 Hour 1:25a M. |  |                                                                                                                                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>42 Sinai Hospital</b>                                                                                                                                                                                                               |  |  |  | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 4 Year 1972 Hour 1:25a M.                                                                          |  |                                                                                                                                                             |  |
| 6. SEX <b>female</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 7. RACE <b>negro</b>                                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH <b>8-8-53</b>                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 10. AGE (In years last birthday) <b>19</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                      |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2798</b>                          |  |
| 11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>                                                                                                                                                                                                                                                                                                                                                   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                |  | 13. FATHER'S NAME <b>TRUST BROWN</b>                                                                                                                        |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                   |  |  |  | 14B. KIND OF BUSINESS OR INDUSTRY <b>STUDENT</b>                                                                                          |  | 15. MOTHER'S MAIDEN NAME <b>LILLIAN WILSON</b>                                                                                                              |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                       |  |  |  | 17. SOCIAL SECURITY NO. <b>STUDENT</b>                                                                                                    |  | 18. INFORMANT <b>LILLIAN EATMAN</b> ADDRESS <b>129 N. MONASTERY AVENUE</b>                                                                                  |  |
| 19. <b>E965 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>Gunshot wound of head</b>                                                                                                                                 |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                              |  |                                                                                                                                                             |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  |  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                |  |                                                                                                                                                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                        |  |  |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  |                                                                                                                                                             |  |
| 21. AUTOPSY? (Yes or No) <b>yes</b>                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  |  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>                                    |  |                                                                                                                                                             |  |
| 22C. WHERE DID INJURY OCCUR? <b>Garrison Ave. &amp; Edgemere St. 2798</b>                                                                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 22D. TIME OF INJURY (APPROX.) <b>9-4-72 1:06 a/</b>                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                         |  |                                                                                                                                                             |  |
| 22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant.</b>                                                                                                                                                                                                                                                                                                                                                  |  |  |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |                                                                                                                                           |  |                                                                                                                                                             |  |
| ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D.                                                                                                                                                                                                                                                                                                                                                                  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                           |  |                                                                                                                                                             |  |
| EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>                                                                                                                                                                                                                                                                                                                                                           |  |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                            |  |                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                                       |  |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 24B. DATE <b>9-7-72</b>                                                                                                                   |  |                                                                                                                                                             |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>SHARP ST. CHURCH CEM.</b>                                                                                                                                                                                                                                                                                                                                               |  |  |  | 24D. LOCATION (City, town, or county) (State) <b>CHASE, MARYLAND</b>                                                                      |  |                                                                                                                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>                                                                                                                                                                                                                                                                                                                                                             |  |  |  | 25B. NAME OF REGISTRAR <b>John J. [unclear]</b>                                                                                           |  |                                                                                                                                                             |  |
| 25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H.</b>                                                                                                                                                                                                                                                                                                                                                         |  |  |  | ADDRESS <b>1701 LAUENS STREET</b>                                                                                                         |  |                                                                                                                                                             |  |



72 08536

BALTIMORE CITY HEALTH DEPARTMENT

72 08536

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>ASA RICHARDSON, JR.</b>                                                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                                      |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(If not in hospital or institution, give street address or location)<br><b>3330 1/2 Garrison Blvd., Apt. C-2</b>                                                                                                                                                                                                                                                          |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 4, 1972 11:20 P.</b>                                                                                             |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7. RACE<br><b>Negro</b>                                                                                                                                                         |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                         |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                             |  |
| 9. DATE OF BIRTH<br><b>APRIL 5, 1942</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (In years last birthday) <b>30</b><br>If Under 1 Yr. If Under 24 Hrs.<br>Months Days Hours Min.                                                                         |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 12. CITIZEN OF<br><b>USA</b>                                                                                                                                                    |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                         |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>NATIONAL BREWERY CO.</b>                                                                                                                |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                             |  | 17. SOCIAL SECURITY NO.                                                                                                                                                         |  |
| 18. INFORMANT<br><b>MRS. MARGARET RICHARDSON</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><b>3303 1/2 GARRISON BLVD.</b>                                                                                                                                       |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Overdose of Darvon</b><br><b>Intravenous narcotism</b>                                                                                                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                    |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                      |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                    |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                             |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                              |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                     |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                                                                         |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>3330 1/2 Garrison Blvd., Apt. C-2</b>                                                                                                                                                                                                                                                                                                                |  | 22F. HOW DID INJURY OCCUR?<br><b>Took overdose of Darvon</b>                                                                                                                    |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>Sept. 1-4, 1972</b>                                                                                                                                                                                                                                                                                                                                                 |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                            |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <del>Natural causes</del> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |                                                                                                                                                                                 |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>                                                                                                                                                                                                                                                                                                                                                       |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br><b>9/5/72</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 24B. DATE<br><b>9-8-72</b>                                                                                                                                                      |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>MARYLAND NATIONAL CEMETERY</b>                                                                                                                                                                                                                                                                                                                                                             |  | 24D. LOCATION (City, town, or county) (State)<br><b>LAUREL, MARYLAND</b>                                                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 7 1972</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br><b>Lidney</b>                                                                                                                                         |  |
| 25C. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT FUNERAL HOMES</b>                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><b>1701 LAURENS ST.</b>                                                                                                                                              |  |

10-24-1972 - Letter from the Office of the Chief Medical Examiner,  
Ronald N. Kornblum, M.D.-Deputy Chief Medical Examiner. HRS



R-216

72 08597 STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08597

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                    |                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>ERNEST RISPER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year<br><b>September 3, 1972</b>              |                                                                    | Hour<br>M.                                                                                                            |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Provident Hospital (DOA)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>September 3, 1972</b>                                                                                       |                                                                    | Hour<br><b>7:20 A.</b>                                                                                                |
| 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)<br>A. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | B. COUNTY<br><b>2301</b>                                                                                                                                    |                                                                    |                                                                                                                       |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. RACE<br><b>Negro</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                   |
| 9. DATE OF BIRTH<br><b>11-12-41</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 10. AGE (in years lost birthday)<br><b>30</b>                                                                                                               | E. STREET AND NUMBER<br><b>1009 S. Hanover Street</b>              |                                                                                                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 12. CITIZEN OF<br><b>U.S.A.</b>                                                                                                                             |                                                                    | 13. FATHER'S NAME<br><b>JOHN E. RISPER</b>                                                                            |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STOCK CLERK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                    | 15. MOTHER'S MAIDEN NAME<br><b>JUANITA FAUNTLEROY</b>                                                                 |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 17. SOCIAL SECURITY NO.<br><b>214-38-9218</b>                                                                                                               |                                                                    | 18. INFORMANT ADDRESS<br><b>JOHN E. RISPER 2423 W. COLDSRING LANE</b>                                                 |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>E-965-X</b><br>(A) IMMEDIATE CAUSE <u>Gunshot wound of abdomen</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                          |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                    | 21. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>building</b>                                                 |                                                                    | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?<br><b>Bakesbury Court at Presbury Street</b> |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>9-3-72 6:30 A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                        |                                                                    | 22F. HOW DID INJURY OCCUR?<br><b>Shot by unknown assailant</b>                                                        |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <u>Peter Lipkovic</u> M.D.<br>EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>September 3, 1972</b> |                         |                                                                                                                                                             |                                                                    |                                                                                                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 24B. DATE<br><b>9-7-72</b>                                                                                                                                  | 24C. NAME of CEMETERY or CREMATORY<br><b>ARBUTUS MEMORIAL PARK</b> |                                                                                                                       |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 7 1972</b>                                                                                                        |                                                                    |                                                                                                                       |
| 25B. NAME OF REGISTRAR<br><b>Bridget H. Horton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>MORTON &amp; DYETT F. H. 1701 LAURENS ST.</b>                                                                           |                                                                    |                                                                                                                       |

11-12-11

11-12-11

11-12-11

7-7

11-12-11



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08598

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) JAMES KEAVNEY2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)3. DATE PRONOUNCED DEAD Month Day Year Hour  
September 5, 1972 8:02 A. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY 302

6. SEX Male

7. RACE White

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?  
YES ☒ NO ☐

9. DATE OF BIRTH 12-17-24

10. AGE (In years last birthday) 47  
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER 800 E. Baltimore Street

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas B. Keavney

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman

14B. KIND OF BUSINESS OR INDUSTRY Shipping

15. MOTHER'S MAIDEN NAME Catherine Casey

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES

17. SOCIAL SECURITY NO. 218-18-3862

18. INFORMANT ADDRESS Raymond Keavney 8411 Nunley Dr

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH Cirrhosis of liver

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/72

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 9/8/72

24C. NAME of CEMETERY or CREMATORY Parkwood

24D. LOCATION (City, town, or county) (State) Balto Md

25A. DATE REC'D BY HEALTH DEPT SEP 7 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

September 2, 1971

W. J. Sullivan

James A. Sullivan

Robert A. Sullivan

1971-1972

Statement of Work

W. J. Sullivan

92

|                                                                                                                                                                                                       |  |                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) JOSEPH BURRELL                                                                                                                                                 |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>MARYLAND STATE PENITENTIARY |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>September 4, 1972 3:20 P. M.                                                                              |  |
| 6. SEX<br>Male                                                                                                                                                                                        |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7. RACE<br>Negro                                                                                                                                                                                      |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                |  |
| 10. AGE (In years last birthday) 29                                                                                                                                                                   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  |
| 11. BIRTHPLACE (State or foreign country)<br>Ind.                                                                                                                                                     |  | E. STREET AND NUMBER<br>909 Somerset Street                                                                                                                 |  |
| 12. CITIZEN OF<br>U.S. A.                                                                                                                                                                             |  | 13. FATHER'S NAME<br>William Burrell                                                                                                                        |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>Bessie Benson                                                                                                                   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service)<br>No                                                                                         |  | 17. SOCIAL SECURITY NO.                                                                                                                                     |  |
| 18. INFORMANT<br>Bessie Burrell                                                                                                                                                                       |  | ADDRESS<br>909 Somerset St.                                                                                                                                 |  |

19. CAUSE OF DEATH

E-953X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
Hanging

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Cell #D117

22C. WHERE DID INJURY OCCUR?  
Maryland State Penitentiary

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 9-4-72 3:00 P. m.

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?  
Hanged himself

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 9/5/72

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State)

Burial 9-10-72 Balto. Cem. Balto. Md.

25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS

SEP 7 1972 [Signature] 51101st Funeral Home 1129N. Caroline St.

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THE BODY OF WILLIE, MAE WILLIAMS HAS BEEN RELEASED ON APPROVAL BY DR LIPKOVIC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the CHIEF MEDICAL EXAMINER'S OFFICE OF THE MEDICAL EXAMINER or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 72 08600 CERTIFICATE OF DEATH BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 72 08600 STATE OF MARYLAND-DHMH

BIRTH NO. 1. NAME OF DECEASED (Type or Print) Willie Mae James Williams 2. DATE AND HOUR OF DEATH 09-01-72 11:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205 4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN D. INSIDE CITY LIMITS? YES [X] NO [ ] E. STREET AND NUMBER 747 EDGEWOOD STREET

5. SEX FEMALE 6. RACE NEGRO 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] 8. DATE OF BIRTH 04-13-22 9. AGE (In years lost birthday) 50 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid 11. BIRTHPLACE (State or foreign country) Darlington S.C. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME SAMMIE JAMES 14. MOTHER'S MAIDEN NAME GEORGIANNA GRAY 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 227-30-2355 17. INFORMANT Troy James 747 Edgewood St. ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Irreversible Ventricular Fibrillation CAUSE OF DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1'15" (B) MAJOR SURGERY for (C) DISSECT. THORACO-ABD. ANEURYSM. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) II

19A. DATE OF OPERATION 9-1-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DISSECTING ANEURYSM 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

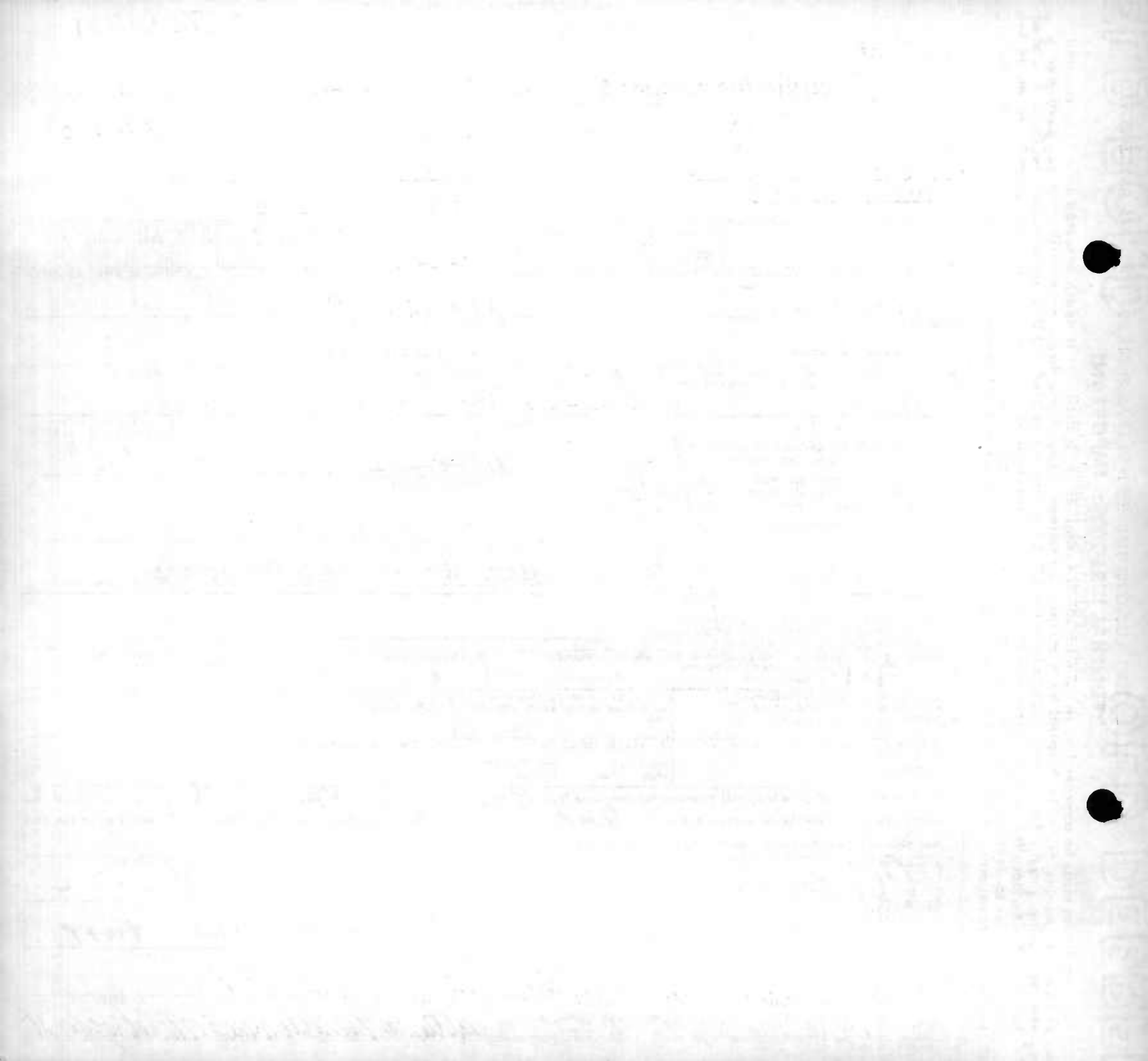
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work [ ] Not While At Work [ ] 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-1-72 to 9-1-72 that (I) (we) last saw the deceased alive on 9-1-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Charles Pappas M.D. DEGREE 23B. DATE SIGNED 9-1-72 23C. PHYSICIAN'S NAME (Type) CHARLES PAPPAS DEGREE 23D. ADDRESS JOHNS HOPKINS HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/6/72 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. 24D. LOCATION (City, town, or county) (State) Balto. Md.

25A. DATE RECD BY HEALTH DEPT. SEP 7 1972 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR 25D. ADDRESS



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08601

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                |     |                                                                                                                                                             |      |                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WALTER WALKER</b>                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                    |  | Month                                                          | Day | Year                                                                                                                                                        | Hour | M.                                                                                            |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1111 N. Gilmore Street</b>                                                                                                                                                                                                              |  | 3. DATE PRONOUNCED DEAD<br>September 5, 1972                                                                                                                                                                                                                                                                                                                                                                             |  | Month                                                          | Day | Year                                                                                                                                                        | Hour | M.                                                                                            |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1602</b>                                                                                                                                                                                                                                                                              |  | 6. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE <b>Negro</b>                                           |     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | C. CITY OR TOWN <b>Baltimore</b>                                                              |
| 9. DATE OF BIRTH <b>12/23/20</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 10. AGE (In years last birthday) <b>52</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 11. BIRTHPLACE (State or foreign country) <b>Va.</b>           |     | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                |      | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13. FATHER'S NAME <b>Walter Walker Sr.</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME <b>Grace Eubanks</b>                  |     | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>                                           |      | 17. SOCIAL SECURITY NO. <b>409-12-7797</b>                                                    |
| 18. INFORMANT <b>Mamie Foster</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>412.4 I</b> |  | 20. DATE OF OPERATION <b>0</b>                                 |     | 21. AUTOPSY? (Yes or No) <b>no</b>                                                                                                                          |      | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)       |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 25. DATE REC'D BY HEALTH DEPT. <b>SEP 7 1972</b>               |     | 26. NAME OF REGISTRAR <b>Sidney</b>                                                                                                                         |      | 27. FUNERAL DIRECTOR <b>Williams Funeral Home</b>                                             |
| 28. DATE <b>9/8/72</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 29. NAME OF CEMETERY or CREMATORY <b>W. H. H. Cemetery</b>                                                                                                                                                                                                                                                                                                                                                               |  | 30. LOCATION (City, town or county) <b>Balto.</b>              |     | 31. ADDRESS <b>318 N. Schroeder St.</b>                                                                                                                     |      | 32. DATE SIGNED <b>9/5/72</b>                                                                 |
| 33. ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 34. EXAMINER'S NAME (Type) <b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 35. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> |     | 36. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                                     |      | 37. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                       |



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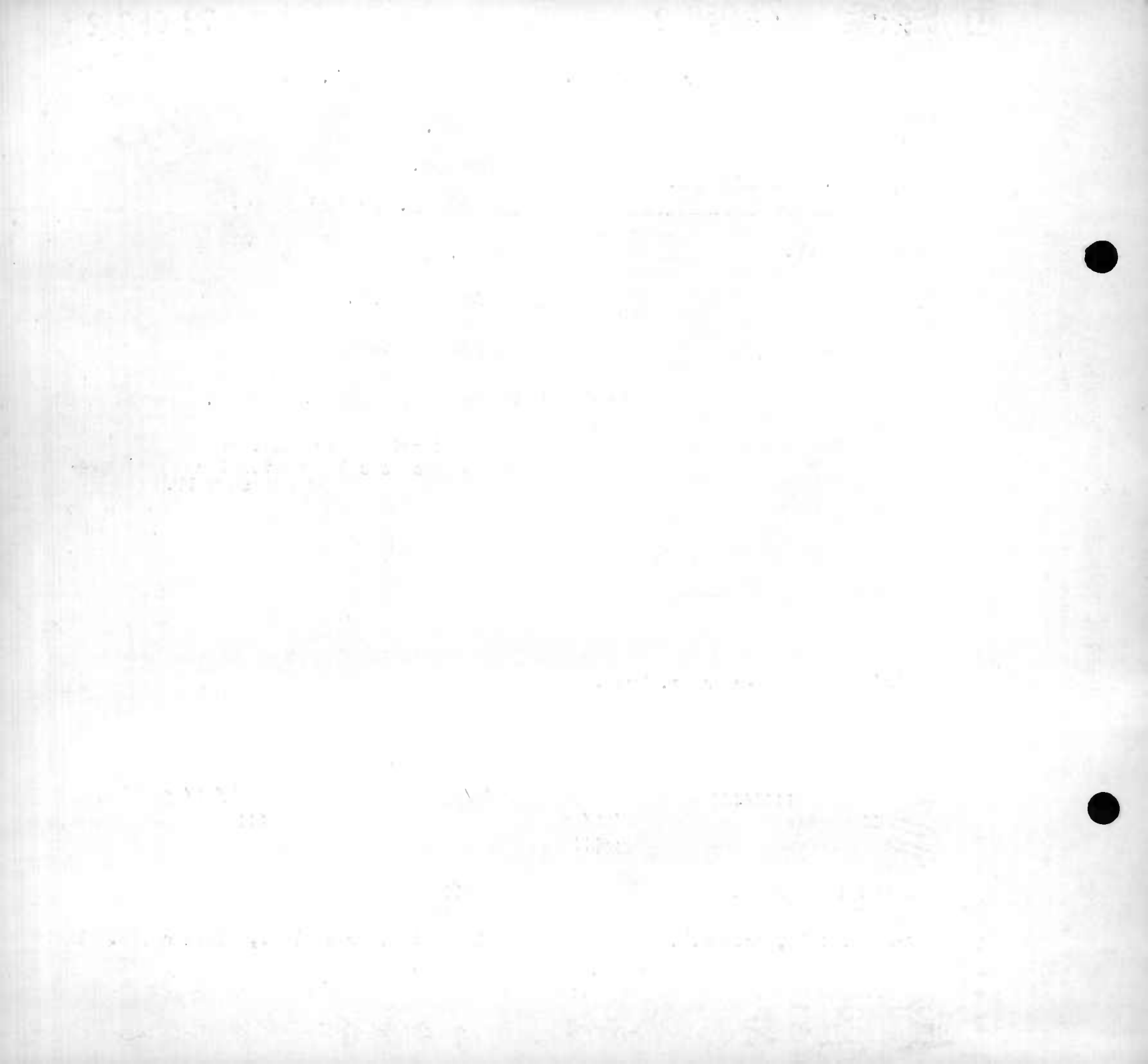
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                                                                                                                                                                                                                                                                                                                                                                                |                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                                                                                                                                                         |                                   | <p>REG. NO. <b>72 08602</b></p> <p><b>STATE OF MARYLAND-DEMD</b></p>                                                                                                                                                                                                                                                                                                           |                                                    |
| <p><b>BIRTH NO.</b> <b>N-425</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <b>ARCHIE NELSON Sr.</b></p>                                                                                                                                                                                                                                                                                                                                                           |                                   | <p><b>2. DATE AND HOUR OF DEATH</b> <b>Sept. 4, 1972</b></p>                                                                                                                                                                                                                                                                                                                   |                                                    |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>00 906 W. Franklin St.</b></p>                                                                                                                                                                                                                                         |                                   | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p><b>A. STATE</b> <b>Md.</b> <b>B. COUNTY</b> <b>1601</b></p> <p><b>C. CITY OR TOWN</b> <b>Balto.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <b>906 W. Franklin St.</b></p> |                                                    |
| <p><b>5. SEX</b> <b>Male</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                          | <p><b>6. RACE</b> <b>Col.</b></p> | <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>                                                                                                                                                                                    | <p><b>8. DATE OF BIRTH</b> <b>Feb. 2, 1928</b></p> |
| <p><b>9. AGE</b> (In years last birthday) <b>44</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                   | <p><b>If Under 1 Yr. Months: Days</b></p>                                                                                                                                                                                                                                                                                                                                      | <p><b>If Under 24 Hrs. Hours: Min.</b></p>         |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b></p>                                                                                                                                                                                                                                                                                                                                             |                                   | <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>2</b></p>                                                                                                                                                                                                                                                                                                                       |                                                    |
| <p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Sumter S.C.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                |                                   | <p><b>12. CITIZEN OF WHAT COUNTRY?</b></p>                                                                                                                                                                                                                                                                                                                                     |                                                    |
| <p><b>13. FATHER'S NAME</b> <b>Dan Nelson</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                   | <p><b>14. MOTHER'S MAIDEN NAME</b> <b>Ida Johnson</b></p>                                                                                                                                                                                                                                                                                                                      |                                                    |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>                                                                                                                                                                                                                                                                                                                                                    |                                   | <p><b>16. SOCIAL SECURITY NO.</b> <b>250-40-5516</b></p>                                                                                                                                                                                                                                                                                                                       |                                                    |
| <p><b>17. INFORMANT</b> <b>Pearlie Nelson</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                   | <p><b>ADDRESS</b> <b>906 W. Franklin St</b></p>                                                                                                                                                                                                                                                                                                                                |                                                    |
| <p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p><b>CAUSE OF DEATH</b> <b>Carcinoma lung Rt. with metastases to mediastinum and chest wall.</b></p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> |                                   | <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>8 mos.</b></p>                                                                                                                                                                                                                                                                                                       |                                                    |
| <p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>                                                                                                                                                                                                                                                                                                           |                                   |                                                                                                                                                                                                                                                                                                                                                                                |                                                    |
| <p><b>19A. DATE OF OPERATION</b> <b>3/8/72</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                   | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Tumor Rt. Lung.</b></p>                                                                                                                                                                                                                                                                                          |                                                    |
| <p><b>20A. AUTOPSY?</b> (Yes or No)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                   | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>                                                                                                                                                                                                                                                                                             |                                                    |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>                                                                                                                                                                                                                                                                                                                                                                       |                                   | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                                                                                                                                                                                                                         |                                                    |
| <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                                                                                                                                                    |                                   | <p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>                                                                                                                                                                                                                                                                                                                  |                                                    |
| <p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                               |                                   | <p><b>21F. HOW DID INJURY OCCUR?</b></p>                                                                                                                                                                                                                                                                                                                                       |                                                    |
| <p><b>22. I certify that (I) (<del>XXXXXX</del>) attended the deceased from <b>3/3/72</b> 19 to <b>8/21/72</b> 19, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (<del>XXXX</del>) (did not) view the body after death.</b></p>                                                                                                                                                                       |                                   |                                                                                                                                                                                                                                                                                                                                                                                |                                                    |
| <p><b>23A. SIGNATURE</b> <i>Fred N. Cole, Jr.</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   | <p><b>23B. DATE SIGNED</b> <b>9/7/72</b></p>                                                                                                                                                                                                                                                                                                                                   |                                                    |
| <p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>Fred N. Cole, Jr., M.D.</b></p>                                                                                                                                                                                                                                                                                                                                                                                                 |                                   | <p><b>23D. ADDRESS</b> <b>318 Medical Arts Bldg., Baltimore, Md. 21201</b></p>                                                                                                                                                                                                                                                                                                 |                                                    |
| <p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>                                                                                                                                                                                                                                                                                                                                                                                                      |                                   | <p><b>24B. DATE</b> <b>9/9/72</b></p>                                                                                                                                                                                                                                                                                                                                          |                                                    |
| <p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Bimini</b></p>                                                                                                                                                                                                                                                                                                                                                                                                            |                                   | <p><b>24D. LOCATION</b> (City, town, or county) (State) <b>South Par.</b></p>                                                                                                                                                                                                                                                                                                  |                                                    |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 7 1972</b></p>                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | <p><b>25B. NAME OF REGISTRAR</b> <i>Sidney W. Horton</i></p>                                                                                                                                                                                                                                                                                                                   |                                                    |
| <p><b>25C. FUNERAL DIRECTOR</b> <i>Wm. F. H. 319 N. Schaefer St</i></p>                                                                                                                                                                                                                                                                                                                                                                                                   |                                   | <p><b>ADDRESS</b></p>                                                                                                                                                                                                                                                                                                                                                          |                                                    |



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

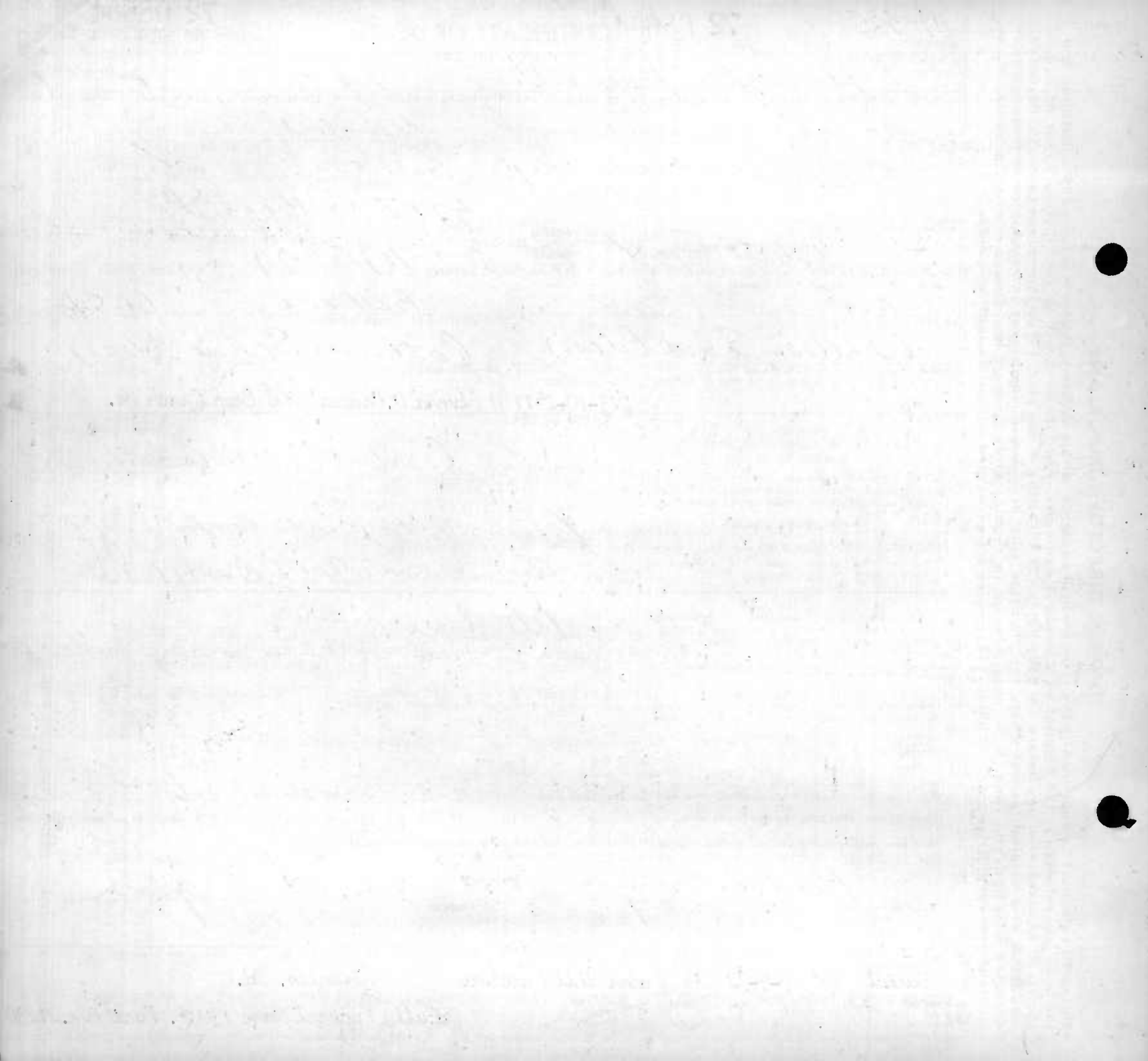
|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| S-300                                                                                                                                                                                                                                                                                                                    |  | 72 08603                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                    |  | REG. NO. 72 08603                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                |  | 1. NAME OF DECEASED<br>(Type or Print) Clifton Seth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE AND HOUR OF DEATH<br>Sept. 6, 1972                                                                                                                                          |  | 3:30 A.M.                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY Caroline                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. CITY OR TOWN<br>Denton, Md.                                                                                                                                                      |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31<br>Baltimore City Hospitals<br>4940 Eastern Ave.<br>Baltimore, Md. 21224                                                                                                                                                                                                      |  | E. STREET AND NUMBER<br>Route 3 Box 131 Denton, Md. 21269                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. DATE OF BIRTH<br>Jan. 15, 1908                                                                                                                                                   |  | 7. AGE (In years last birthday)<br>64                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                           |  | 6. RACE<br>Negro                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                         |  | 8. DATE OF BIRTH<br>Jan. 15, 1908                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                                                                                                                                   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. BIRTHPLACE (State or foreign country)<br>Easton, Maryland                                                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 13. FATHER'S NAME<br>Stephen Jackson                                                                                                                                                                                                                                                                                     |  | 14. MOTHER'S MAIDEN NAME<br>Margaret Skinner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                      |  | 16. SOCIAL SECURITY NO.<br>21322-7808                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 17. INFORMANT<br>BCH Records: Baltimore, Md. 21224                                                                                                                                                                                                                                                                       |  | 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>2050<br>SEPTIC (Pseudomonas)<br>DAYS<br>ACUTE MYELOGENOUS LEUKEMIA<br>MONTHS<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | 19. DATE OF OPERATION<br>19. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No)<br>NO<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR? |  |
| 22. I certify that (I) (this hospital) attended the deceased from July 13, 1972 to Sept. 6, 1972 and that (I) (we) last saw the deceased alive on Sept. 6, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  | 23A. SIGNATURE<br>M-fu Tsan M.D. Ph.D.<br>23C. PHYSICIAN'S NAME (Type)<br>M-fu Tsan M.D. Ph.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 23B. DATE SIGNED<br>9/6/72<br>23D. ADDRESS<br>Baltimore City Hospitals<br>4940 Eastern Ave. Baltimore, Md. 21224                                                                    |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial<br>24B. DATE<br>9/9/1972<br>24C. NAME OF CEMETERY OR CREMATORY<br>Hammond Cemetery<br>24D. LOCATION (City, town, or county) (State)<br>Easton, Talbot, Maryland                                                                                                                                                                                                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 7 1972                                                                                                                                                                                                                                                                            |  | 25B. NAME OF REGISTRAR<br>L. H. Hill                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 25C. FUNERAL DIRECTOR<br>L. H. Hill                                                                                                                                                 |  | 25D. ADDRESS<br>Denton, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |



# FUNERAL DIRECTOR: IMPORTANT

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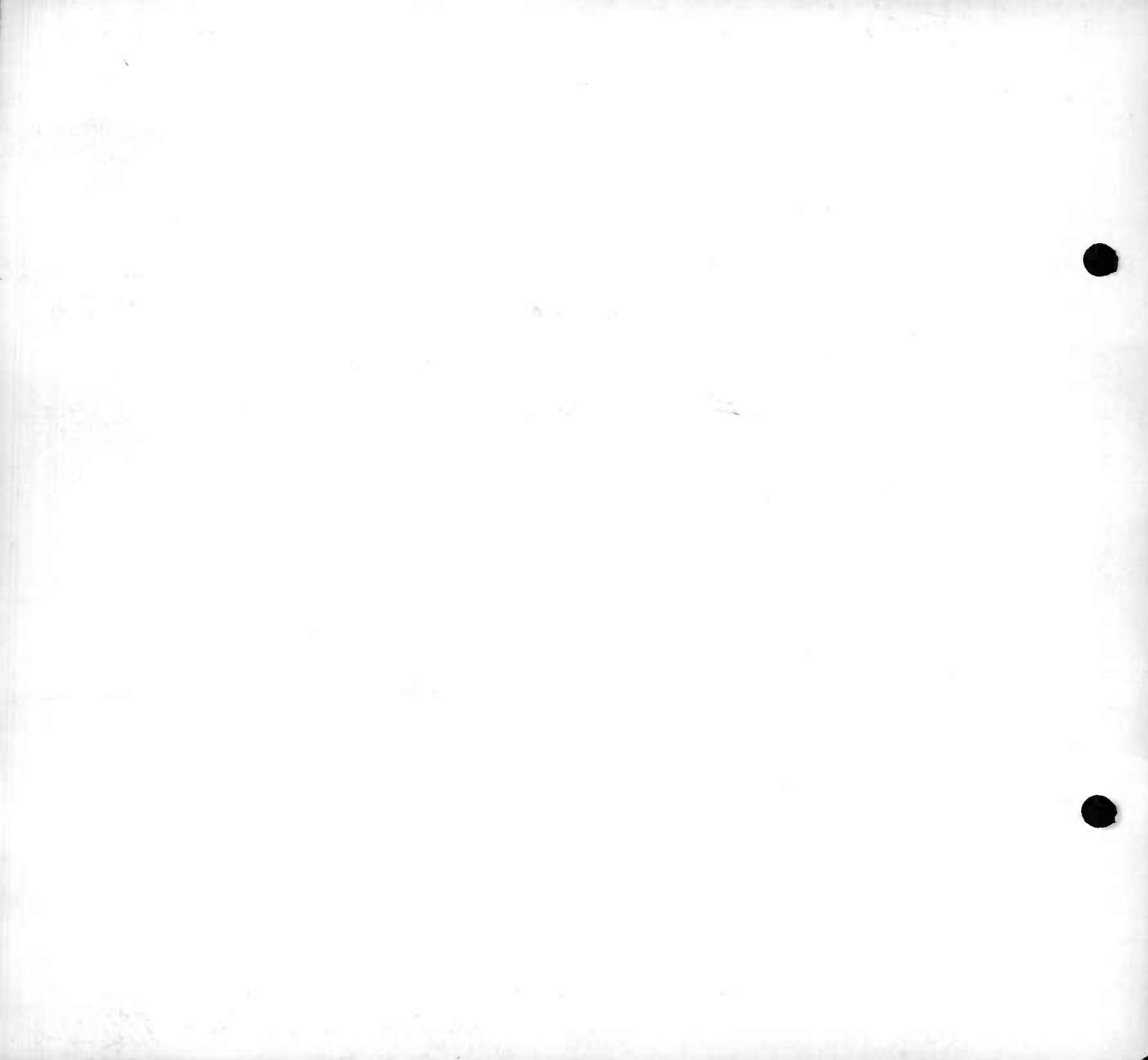
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| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                  |                         | REG. NO. <b>72 08604</b>                                                                                                                                    |                                                                                               |
| M-525                                                                                                                                                                                                                                                                                                                                             |                         | 72 08604                                                                                                                                                    |                                                                                               |
| <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Moranaghan Nellie V.</i>                                                                                                                                                                                                                                                                                |                         | 2. DATE AND HOUR OF DEATH<br><i>9-8-72</i> <i>2:25 P.M.</i>                                                                                                 |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                            |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> 8. COUNTY <i>2402</i>                     |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>43 South Baltimore General Hosp.</i>                                                                                                                                                                                                                                                                   |                         | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                         | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                              |                         | E. STREET AND NUMBER<br><i>521 E. G. Hings St.</i>                                                                                                          |                                                                                               |
| 5. SEX<br><i>F</i>                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>8-1-1895</i>                                                           |
| 9. AGE (In years last birthday)<br><i>77</i>                                                                                                                                                                                                                                                                                                      |                         | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                                   |                                                                                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>None</i>                                                                                                                                                                                                                                        |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                               |
| 11. FATHER'S NAME<br><i>William Smoot (decd.)</i>                                                                                                                                                                                                                                                                                                 |                         | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                               |                                                                                               |
| 13. MOTHER'S MAIDEN NAME<br><i>Catherine Schorer (decd.)</i>                                                                                                                                                                                                                                                                                      |                         | 14. BIRTHPLACE (State or foreign country)<br><i>Baltimore</i>                                                                                               |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                                             |                         | 16. SOCIAL SECURITY NO.<br><i>215-10-2411 D</i>                                                                                                             |                                                                                               |
| 17. INFORMANT<br><i>Elvera D. Braver</i>                                                                                                                                                                                                                                                                                                          |                         | ADDRESS<br><i>8206 Bear Creek Dr.</i>                                                                                                                       |                                                                                               |
| 18. <i>412.1 17250.9</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                          |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Cerebral Vascular Accident</i>                                               |                                                                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                    |                         | (B) <i>Diagnosis: Cerebral Vascular Heart Disease M.I.</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <i>Hypertension M.I. Diabetes Mellitus</i>             |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                            |                         | <i>Atrial fibrillation.</i>                                                                                                                                 |                                                                                               |
| 19A. DATE OF OPERATION<br><i>0</i>                                                                                                                                                                                                                                                                                                                |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                               |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                         |                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                    |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                               |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                       |                         | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                             |                                                                                               |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                         |                         | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-5</i> <i>1972</i> to <i>9-6</i> <i>1972</i> , that (I) (we) last saw the deceased alive on <i>9-6</i> <i>1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                               |
| 23A. SIGNATURE<br><i>Helen Song</i>                                                                                                                                                                                                                                                                                                               |                         | 23B. DATE SIGNED<br><i>9-8-72</i>                                                                                                                           |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><i>DEGREE</i>                                                                                                                                                                                                                                                                                                     |                         | 23D. ADDRESS<br><i>DEGREE</i>                                                                                                                               |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                         |                         | 24B. DATE<br><i>9-9-72</i>                                                                                                                                  |                                                                                               |
| 24C. NAME OF CEMETERY or CREMATORY<br><i>Cedar Hill Cemetery</i>                                                                                                                                                                                                                                                                                  |                         | 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>                                                                                          |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 8 1972</i>                                                                                                                                                                                                                                                                                              |                         | 25B. NAME OF REGISTRAR<br><i>Ludwig</i>                                                                                                                     |                                                                                               |
| 25C. FUNERAL DIRECTOR<br><i>McGully Funeral Home</i>                                                                                                                                                                                                                                                                                              |                         | ADDRESS<br><i>130 E. Fort Ave. 21230</i>                                                                                                                    |                                                                                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| I-516                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 72 08605                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                             |  | REG. NO. 72 08605                                                                                                                                        |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | STATE OF MARYLAND-DIVISION                                                                                                                   |  |                                                                                                                                                          |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Mr John E. Imhoff</u>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><u>9-5-72</u> <u>1 20</u> P.M.                                                                                  |  |                                                                                                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><u>34 Bon Secours Hospital.</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> |  |                                                                                                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Bon Secours Hospital.</u>                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                          |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                            |  |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 6. RACE <u>White</u>                                                                                                                         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><u>03-19-06</u>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 9. AGE (in years last birthday)<br><u>66</u>                                                                                                 |  | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.                                                                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Unemployed</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Pharmacy Co.</u>                                                                                     |  | 11. BIRTHPLACE (State or foreign country)<br><u>md</u>                                                                                                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 13. FATHER'S NAME<br><u>John Imhoff</u>                                                                                                      |  |                                                                                                                                                          |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Elsa Sanders</u>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>yes World War II</u>          |  |                                                                                                                                                          |  |
| 16. SOCIAL SECURITY NO.<br><u>210-090218</u>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 17. INFORMANT<br><u>Dr's Chart Bon Secours Hosp.</u>                                                                                         |  |                                                                                                                                                          |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>D.T. 2° to cirrhosis of liver (chronic)</u><br><u>Chronic alcoholism years</u> |  |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                 |  |                                                                                                                                                          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                          |  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                                                                       |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                  |  |                                                                                                                                                          |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                                                                                |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                   |  |                                                                                                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>sep 1</u> 19 <u>72</u> to <u>sep 5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>sep 5</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                    |  |                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                          |  |
| 23A. SIGNATURE<br><u>C. J. Ahn</u>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 23B. DATE SIGNED<br><u>Sep 5 '72</u>                                                                                                         |  | 23C. PHYSICIAN'S NAME (Type)<br><u>CHOON JA AHN</u>                                                                                                      |  |
| 23D. ADDRESS<br><u>Bon Secours hosp.</u>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | 23E. DEGREE                                                                                                                                  |  |                                                                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br><u>9/7/72</u>                                                                                |  | 24C. NAME of CEMETERY or CREMATORY<br><u>Louisa Park Cem.</u>                                                                                |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>                                                                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 8 1972</u>                                                                                                                                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR<br><u>John E. Imhoff</u>                                                           |  | 25C. FUNERAL DIRECTOR<br><u>John E. Imhoff</u>                                                                                               |  | 25D. ADDRESS<br><u>Hollis St.</u>                                                                                                                        |  |

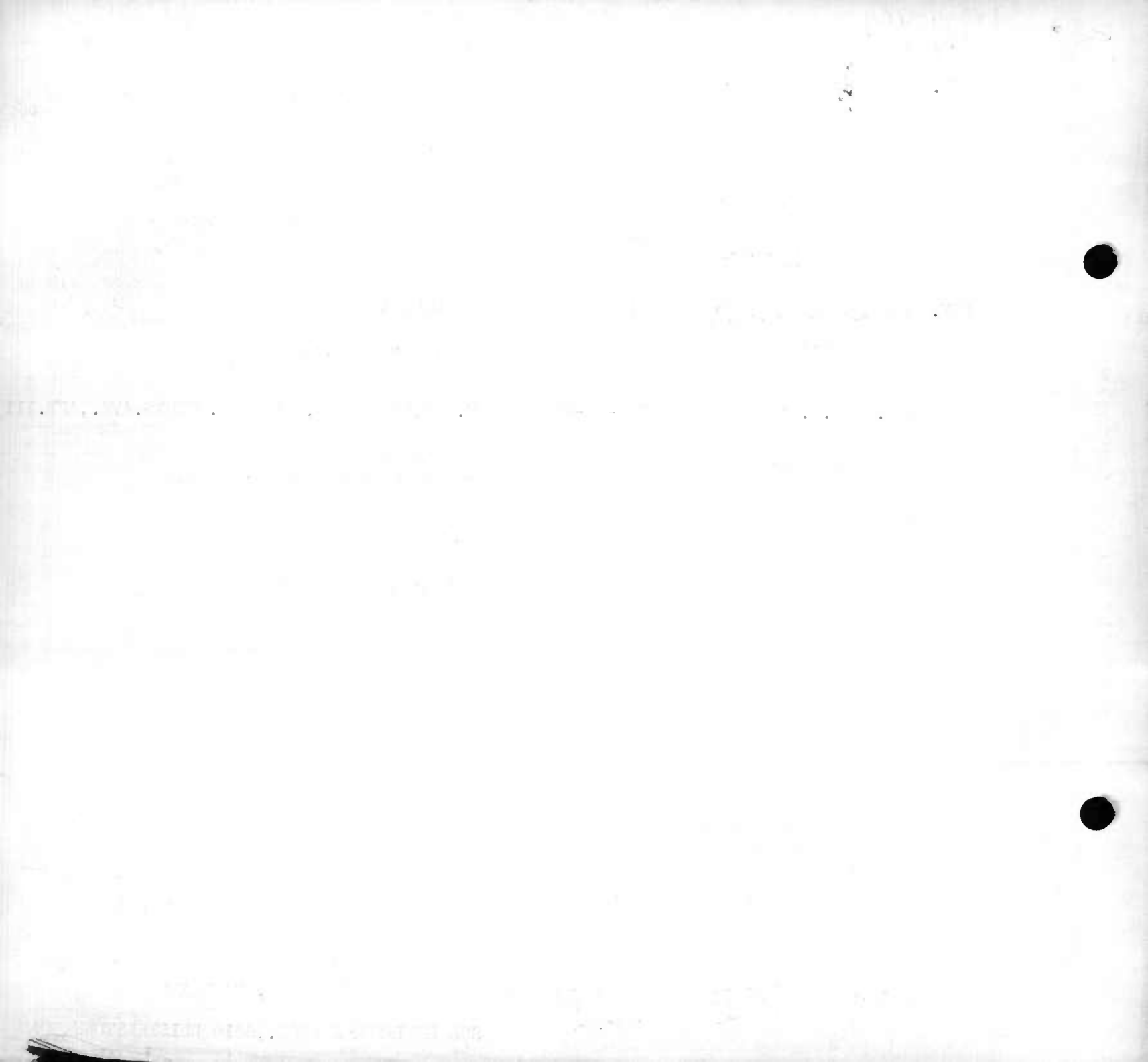




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>72 08606<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                                                            | REG. NO. 72 08606<br>STATE OF MARYLAND-DEMD                                                                                                                                                                                                                                                    |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 11-460                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 1. NAME OF DECEASED<br>(Type or Print)<br>DR. JACOB M. MILLER                                                                                               |                                                                            | 2. DATE AND HOUR OF DEATH<br>9/4/72 18:30 P. M.                                                                                                                                                                                                                                                |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>SINAI HOSPITAL<br>BELVEDERE + GREENSPRING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                                                            | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE MD. B. COUNTY 2730<br>C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 7111 PK. HGHTS. AVE. APT. 111 |                                                           |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>8/5/00                                                 | 9. AGE (In years last birthday)<br>72                                                                                                                                                                                                                                                          | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>PHYS. RETIRED M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>MEDICINE                                                                                                               | 11. BIRTHPLACE (State or foreign country)<br>RUSSIA                        |                                                                                                                                                                                                                                                                                                | 12. CITIZEN OF WHAT COUNTRY?<br>USA                       |
| 13. FATHER'S NAME<br>MANUEL MILLER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br>ESTHER MURUCHNICK                              |                                                                                                                                                                                                                                                                                                |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>YES. W.W. II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 16. SOCIAL SECURITY NO.<br>220-44-5289A                                                                                                                     | 17. INFORMANT ADDRESS<br>MRS. MITZI MILLER, 7111 PK. HGHTS. AVE., APT. 111 |                                                                                                                                                                                                                                                                                                |                                                           |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>250.9 I<br>CVA<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>CARDIORESPIRATORY ARREST<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>MI<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>Diabetes Mellitus<br>(C) _____<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                  |                                                                                                                                                             |                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                   |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                       |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                            | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                     |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                |                                                           |
| 23A. SIGNATURE<br>Herbert M. Shuman, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                                                                            | 23B. DATE SIGNED<br>9/4/72                                                                                                                                                                                                                                                                     |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br>HERBERT M. SHUMAN, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             |                                                                            | 23D. ADDRESS<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                   |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 24B. DATE<br>9/6/1972                                                                                                                                       |                                                                            | 24C. NAME of CEMETERY or CREMATORY<br>HERBEN FRIENDSHIP                                                                                                                                                                                                                                        |                                                           |
| 24D. LOCATION<br>BALTIMORE, MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 8 1972                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                |                                                           |
| 25B. NAME OF REGISTRAR<br>Aisley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 25C. FUNERAL DIRECTOR ADDRESS<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                             |                   |                                                                                                                                                                                                                                                                                                               |  | REG. NO. 72 08607                                                                                      |                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|------------------------------------|
| 72 08607                                                                                                                                     |                   |                                                                                                                                                                                                                                                                                                               |  | STATE OF MARYLAND-DMH                                                                                  |                                    |
| BIRTH NO. 11-230                                                                                                                             |                   | 1. NAME OF DECEASED (Type or Print) WEST, WILLIAM ARNOLD                                                                                                                                                                                                                                                      |  |                                                                                                        |                                    |
| 2. DATE AND HOUR OF DEATH                                                                                                                    |                   | SEPTEMBER 6, 1972   6:25 P.M.                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                       |                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                                                                                                         |  |                                                                                                        |                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                    |                   | A. STATE MARYLAND                                                                                                                                                                                                                                                                                             |  | B. COUNTY 1902                                                                                         |                                    |
| 40 ST. AGNES HOSPITAL                                                                                                                        |                   | C. CITY OR TOWN BALTIMORE                                                                                                                                                                                                                                                                                     |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |                                    |
|                                                                                                                                              |                   | E. STREET AND NUMBER N 19 SOUTH CALHOUN STREET                                                                                                                                                                                                                                                                |  | 21223                                                                                                  |                                    |
| 5. SEX MALE                                                                                                                                  | 6. RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                      |  | 8. DATE OF BIRTH 08 04 00                                                                              | 9. AGE (In years last birthday) 72 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER                                       |                   | 10B. KIND OF BUSINESS OR INDUSTRY Mining                                                                                                                                                                                                                                                                      |  | 11. BIRTHPLACE (State or foreign country) TENNESSEE                                                    |                                    |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                          |                   | 13. FATHER'S NAME MARTIN WEST (DECD)                                                                                                                                                                                                                                                                          |  | 14. MOTHER'S MAIDEN NAME HARRIETT Cole DECD                                                            |                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) NO                                  |                   | 16. SOCIAL SECURITY NO. 401-01-3681                                                                                                                                                                                                                                                                           |  | 17. INFORMANT ADDRESS BALTIMORE MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE                   |                                    |
| 18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                   |                   | CAUSE OF DEATH Chronic Congestive Heart Failure due probably to ASIA                                                                                                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                           |                                    |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |                   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Obstructive Pulmonary Disease                                                                                                                                                                                                                     |  |                                                                                                        |                                    |
| ANTECEDENT CAUSES                                                                                                                            |                   | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                    |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |                   | (C)                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                    |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).          |                   | Peptic Ulcer Disease with GI Bleeding                                                                                                                                                                                                                                                                         |  |                                                                                                        |                                    |
| 19A. DATE OF OPERATION 0                                                                                                                     |                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                              |  | 20A. AUTOPSY? (Yes or No) NO                                                                           |                                    |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                         |                   | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                    |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                     |                   | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                    |
| 21F. HOW DID INJURY OCCUR?                                                                                                                   |                   | 22. I certify that (X) (this hospital) attended the deceased from AUGUST 21 1972 to SEPTEMBER 6 1972, that XX (we) last saw the deceased alive on SEPTEMBER 6 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) view the body after death. |  |                                                                                                        |                                    |
| 23A. SIGNATURE Joseph H. Miller, M.D.                                                                                                        |                   | 23B. DATE SIGNED 9-6-72                                                                                                                                                                                                                                                                                       |  | 23C. PHYSICIAN'S NAME (Type) JOSEPH H. MILLER, M.D.                                                    |                                    |
| 23D. ADDRESS WILKENS AVE. 21229 ST AGNES HOSPITAL RECORDS CATON &                                                                            |                   | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                               |  | 24B. DATE 9/9/72                                                                                       |                                    |
| 24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem Park                                                                                      |                   | 24D. LOCATION (City, town, or county) Howard Co., Maryland                                                                                                                                                                                                                                                    |  | (State)                                                                                                |                                    |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 8 1972                                                                                                   |                   | 25B. NAME OF REGISTRAR                                                                                                                                                                                                                                                                                        |  | 25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker Streets 21223                      |                                    |

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

10 SOUTH CALHOUN STREET

XXX

CAUCASIAN

MALE

W-1

COAL MINER

(DECE)

MARTIN WEST

BALTIMORE HARBOR

NO. 1-01

NO.

SEPTEMBER 22

AUGUST 21

XX

SEPTEMBER 22

XXXX

XX

WILKINS AVE.

ST. AGNES HOSPITAL RECORDS

ST. AGNES HOSPITAL

ST. AGNES

ST. AGNES

# FUNERAL DIRECTOR: IMPORTANT

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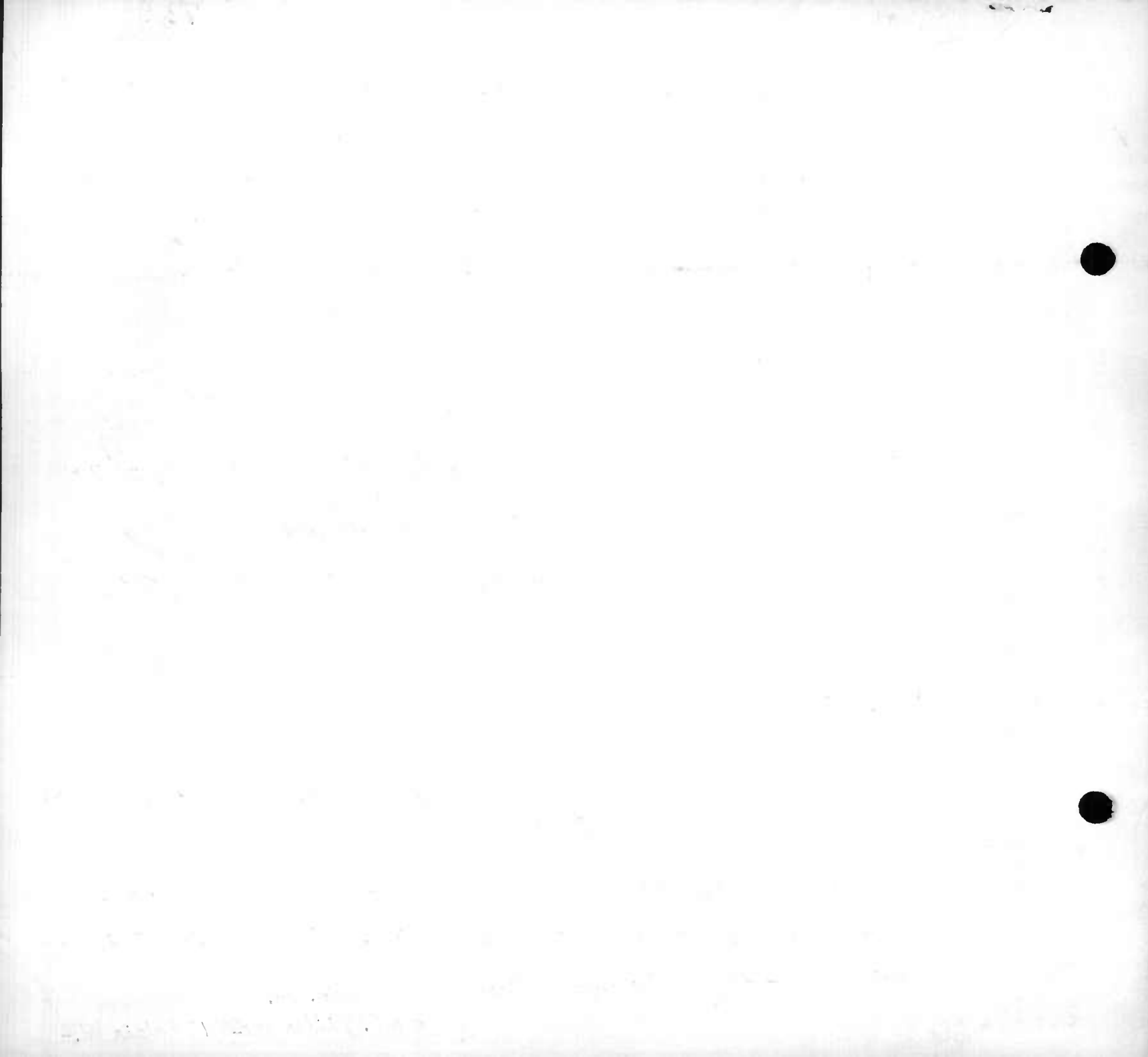
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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| B-656 72 08608                                                                                                                                                                                                                                                                                                                    |                            | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                             |                                     | 72 08608                                                                                                                        |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                         |                            | REG. NO.                                                                                                                                                    |                                     | STATE OF MARYLAND-DEATH                                                                                                         |
| 1. NAME OF DECEASED<br>(Type or Print) <b>CLEMENIA BRAUNER</b>                                                                                                                                                                                                                                                                    |                            | 2. DATE AND HOUR OF DEATH<br><b>9-6-72 9:15 AM.</b>                                                                                                         |                                     |                                                                                                                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                            |                            | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b>                   |                                     |                                                                                                                                 |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>CHURCH HOME &amp; HOSP. BALTO, MD. 35</b>                                                                                                                                                                         |                            | C. CITY OR TOWN <b>ESSEX</b>                                                                                                                                |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                        |
|                                                                                                                                                                                                                                                                                                                                   |                            | E. STREET AND NUMBER<br><b>412 LORRAINE AVE</b>                                                                                                             |                                     |                                                                                                                                 |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>W</b>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-30-89</b> | 9. AGE (In years last birthday) <b>82</b>                                                                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOME MAKER</b>                                                                                                                                                                                                                  |                            | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>                                                                    |
| 13. FATHER'S NAME<br><b>DANIEL AMIDON</b>                                                                                                                                                                                                                                                                                         |                            | 14. MOTHER'S MAIDEN NAME<br><b>EMMA KEYS</b>                                                                                                                |                                     |                                                                                                                                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                             |                            | 16. SOCIAL SECURITY NO.<br><b>219-22-3200</b>                                                                                                               |                                     | 17. INFORMANT<br><b>HOSPITAL CHART</b>                                                                                          |
| 18. <b>436.0 14250.9</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b>                                                                                |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                     |                                                                                                                                 |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                    |                            | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cerebrovascular Accident</b>                                                                   |                                     | <b>2 weeks</b>                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                   |                            | (B) <b>HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                  |                                     | <b>YEARS</b>                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                   |                            | (C)                                                                                                                                                         |                                     |                                                                                                                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                            |                            | <b>DIABETES MELLITUS</b>                                                                                                                                    |                                     | <b>YEARS</b>                                                                                                                    |
| 19A. DATE OF OPERATION<br><b>NONE</b>                                                                                                                                                                                                                                                                                             |                            | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                     | 20A. AUTOPSY? (Yes or No)                                                                                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                             |                            | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                     |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                      |                            | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                     | 21F. HOW DID INJURY OCCUR?                                                                                                      |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8-16-72</b> 19 to <b>9-6-72</b> 19<br>that (I) (we) last saw the deceased alive on <b>9-6-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                            |                                                                                                                                                             |                                     |                                                                                                                                 |
| 23A. SIGNATURE<br><b>Bernard Yukna MD</b>                                                                                                                                                                                                                                                                                         |                            | 23B. DATE SIGNED<br><b>9-6-72</b>                                                                                                                           |                                     | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><b>BERNARD YUKNA</b>                                                                                                                                                                                                                                                                              |                            | 23D. ADDRESS<br><b>CHURCH HOME &amp; HOSP</b>                                                                                                               |                                     |                                                                                                                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                         | 24B. DATE<br><b>9/9/72</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>MT. CARMEL</b>                                                                                                     |                                     | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD.</b>                                                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 8 1972</b>                                                                                                                                                                                                                                                                              |                            | 25B. NAME OF REGISTRAR<br><b>Arlene Johnston</b>                                                                                                            |                                     | 25C. FUNERAL DIRECTOR<br><b>Consolidated Funeral Home</b>                                                                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

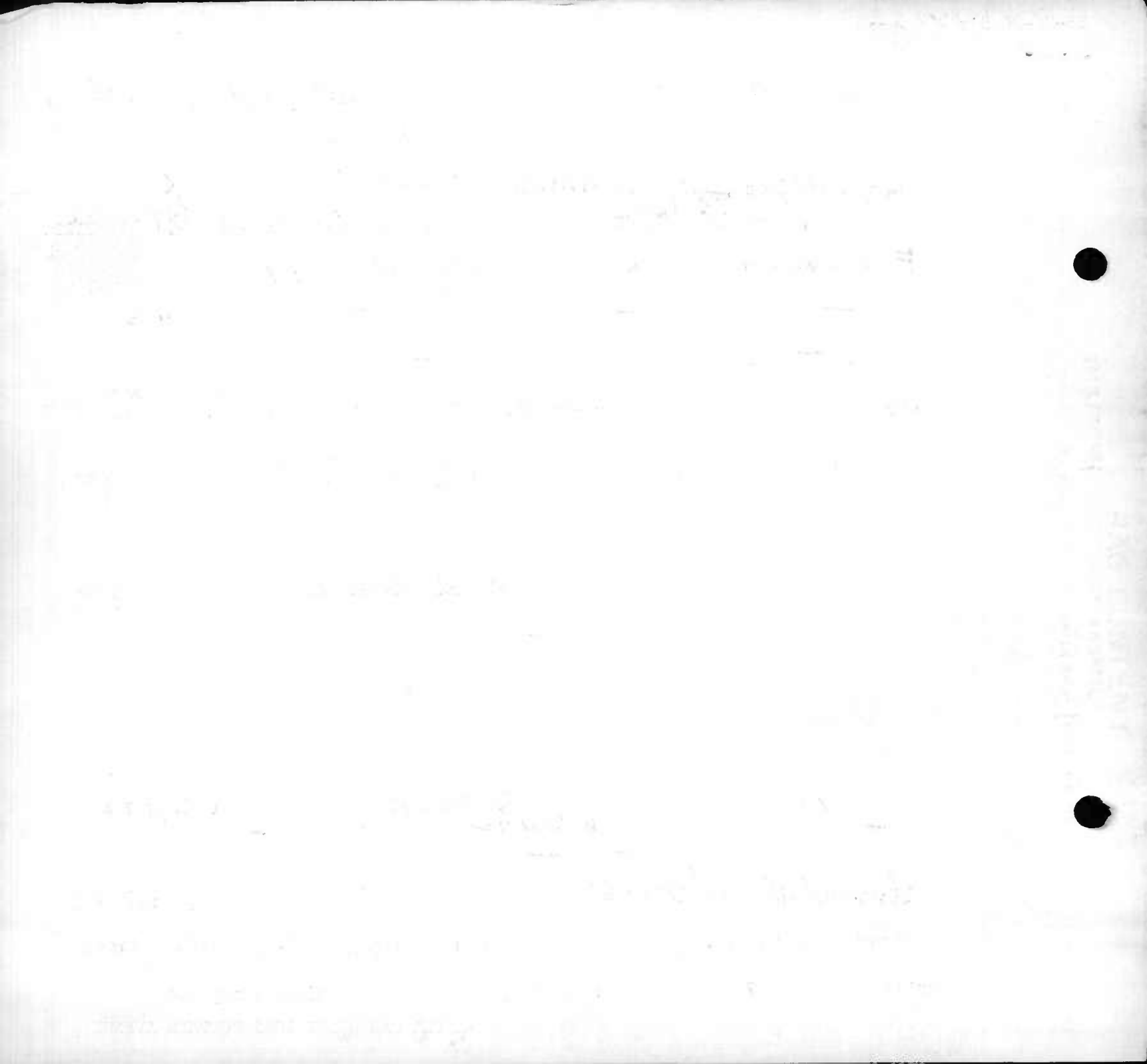
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                                                                                                                                                                              |                                 | 72 08609                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                                                                                                                                                                              |                                 | REG. NO. 72 08609                                         |
| BIRTH NO. <u>D-120</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 72 08609                                                                                                                                                                                                                                                                                                     |                                 |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Davis-Katie Marie</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 2. DATE AND HOUR OF DEATH<br><u>9-2-72</u> <u>9:30 A</u> M.                                                                                                                                                                                                                                                  |                                 |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Bolton Hill Nursing Home</u><br><u>1400 John Stn</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>Balto</u><br>C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <u>6919 Bel Air Rd</u> |                                 |                                                           |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                | 8. DATE OF BIRTH <u>10-9-04</u> | 9. AGE (In years last birthday) <u>68</u>                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                            |                                 | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> |
| 13. FATHER'S NAME <u>Unknown</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>                                                                                                                                                                                                                                                                      |                                 |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                      |                                 | 17. INFORMANT <u>admission sheet</u> ADDRESS              |
| 18. <u>412.3 I</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><br>19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?<br><br>22. I certify that (1) (this hospital) attended the deceased from <u>8/29</u> 19 <u>72</u> to <u>9/2</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>9/2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE <u>[Signature]</u> 23B. DATE SIGNED <u>9/4/72</u><br>23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u> DEGREE <u>MD</u> 23D. ADDRESS <u>272 Beal St Balto Md</u><br>24A. BURIAL CREMATION, REMOVAL, (Specify) <u>Burial</u> 24B. DATE <u>9-6-72</u> 24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u><br>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 8 1972</u> 25B. NAME OF REGISTRAR <u>[Signature]</u> 25C. FUNERAL DIRECTOR <u>John C. Miller Inc</u> ADDRESS <u>6415 Belair Rd.</u> |                  |                                                                                                                                                                                                                                                                                                              |                                 |                                                           |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                     |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                             |  | 72 08610                                                                                                                                                    |  | REG. NO.                                                                                      |  | 72 08610                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                        |  | 2. DATE AND HOUR OF DEATH                                                                                                                                    |  | STATE OF MARYLAND - DEATH                                                                                                                                   |  |                                                                                               |  |                                                         |  |
| LAURA GRAHAM                                                                                                                                                                                                                                                                                                                                  |  | 6 Sept 72 19 40 A.M.                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                               |  |                                                         |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                                                        |  | A. STATE                                                                                                                                                    |  | B. COUNTY                                                                                     |  |                                                         |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31 BALTIMORE CITY HOSPITALS<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                                                                                                                                                       |  | md- 2605                                                                                                                                                     |  | C. CITY OR TOWN<br>BALTO                                                                                                                                    |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                         |  |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                              |  | 6. RACE<br>Caucasian                                                                                                                                         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>17 Jan 1885                                                               |  | 9. AGE (In years lost birthday)<br>87                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                   |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                            |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                          |  |                                                         |  |
| 13. FATHER'S NAME<br>Joseph Gephardt                                                                                                                                                                                                                                                                                                          |  | 14. MOTHER'S MAIDEN NAME<br>-                                                                                                                                |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                              |  | 16. SOCIAL SECURITY NO.<br>216-Q7-5511D                                                       |  | 17. INFORMANT<br>BCH: RECORDS Baltimore, Maryland 21224 |  |
| 18. 593.21<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Arteriosclerotic C.V.D.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Renal Disease |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>yrs                                                                                                         |  |                                                                                               |  |                                                         |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                     |  |                                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                               |  |                                                         |  |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                             |  | 20A. AUTOPSY? (Yes or No)<br>No                                                                                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |                                                         |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |                                                                                               |  |                                                         |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                    |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                               |  |                                                         |  |
| 22. I certify that (1) (this hospital) attended the deceased from 31 Mar 72 to 6 Sept 72 19 that (1) (we) lost saw the deceased alive on 6 Sept 72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.                                |  | 23A. SIGNATURE<br>Edmund Beacham MD                                                                                                                          |  | 23B. DATE SIGNED<br>6 Sept 72                                                                                                                               |  |                                                                                               |  |                                                         |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Edmund Beacham, M.D.                                                                                                                                                                                                                                                                                          |  | 23D. ADDRESS<br>4940 Eastern Avenue Baltimore, Maryland<br>BALTIMORE CITY HOSPITALS                                                                          |  |                                                                                                                                                             |  |                                                                                               |  |                                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br>9-9-72                                                                                                                                          |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                                                                                                     |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                          |  |                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 8 1972                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR<br>[Signature]                                                                                                                        |  | 25C. FUNERAL DIRECTOR<br>WALTER DABROWSKI                                                                                                                   |  | ADDRESS<br>1005 DUNDALK AVENUE                                                                |  |                                                         |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                      |  |                                                                                                                                         |  |                                                                                               |                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|-------------------------------------|
| 7-452                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 72 08611             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                        |  | REG. NO. 72 08611                                                                             |                                     |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | CERTIFICATE OF DEATH |  |                                                                                                                                         |  | STATE OF MARYLAND-DEMT                                                                        |                                     |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Feilinger, MR. NAPOLEON A.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                      |  | 2. DATE AND HOUR OF DEATH<br><i>September 5, 1972 11:10 PM.</i>                                                                         |  |                                                                                               |                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)<br>A. STATE <i>MARYLAND</i> B. COUNTY <i>2711</i> |  |                                                                                               |                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>34 Bon Secours Hospital</i><br><i>2025 St. Fayette St.</i><br><i>Baltimore, Maryland 21223</i>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                      |  | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                     |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     |
| 5. SEX <i>MALE</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                          |  |                      |  | 8. DATE OF BIRTH<br><i>01-20-06</i>                                                                                                     |  | 9. AGE (in years last birthday)<br><i>66</i>                                                  |                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>MANAGER, ROYAL CROWN BOTTLING CO.</i>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                       |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                                  |                                     |
| 13. FATHER'S NAME<br><i>John Feilinger</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  | 14. MOTHER'S MAIDEN NAME<br><i>Not Known JULIA NAIDJA</i>                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                                          |                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>UNKNOWN - NO</i>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                      |  | 16. SOCIAL SECURITY NO.<br><i>705-07-8733</i>                                                                                           |  | 17. INFORMANT<br><i>PATIENT'S hospital chart - Bon Secours Hospital</i>                       |                                     |
| 18. <i>162</i> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><i>Encephalomalacia with cerebral atrophy months</i> |  |                      |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Bronchogenic Carcinoma with metastases to hilar lymph nodes, liver</i>     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>months</i>                                 |                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                      |  |                                                                                                                                         |  |                                                                                               | (B) DUE TO, OR AS A CONSEQUENCE OF: |
| 19A. DATE OF OPERATION<br><i>2</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  | 20A. AUTOPSY? (Yes or No)<br><i>Yes</i>                                                       |                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |                                     |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                      |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?                                                                    |                                     |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Aug 14</i> 19 <i>72</i> to <i>SEP 5 11 PM</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>SEP 5 11 PM</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                     |  |                      |  |                                                                                                                                         |  |                                                                                               |                                     |
| 23A. SIGNATURE<br><i>C. J. Ahn</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                      |  | 23B. DATE SIGNED<br><i>SEP 5 11 PM 72</i>                                                                                               |  | 23C. PHYSICIAN'S NAME (Type)<br><i>CHOON Ja Ahn</i>                                           |                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                      |  | 24B. DATE<br><i>9-9-72</i>                                                                                                              |  | 24C. NAME of CEMETERY or CREMATORY<br><i>Cathedral Cemetery</i>                               |                                     |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 8 1972</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                      |  | 25B. NAME OF REGISTRAR<br><i>Frederick</i>                                                                                              |  | 25C. FUNERAL DIRECTOR<br><i>Frederick</i>                                                     |                                     |

Address does not exist.

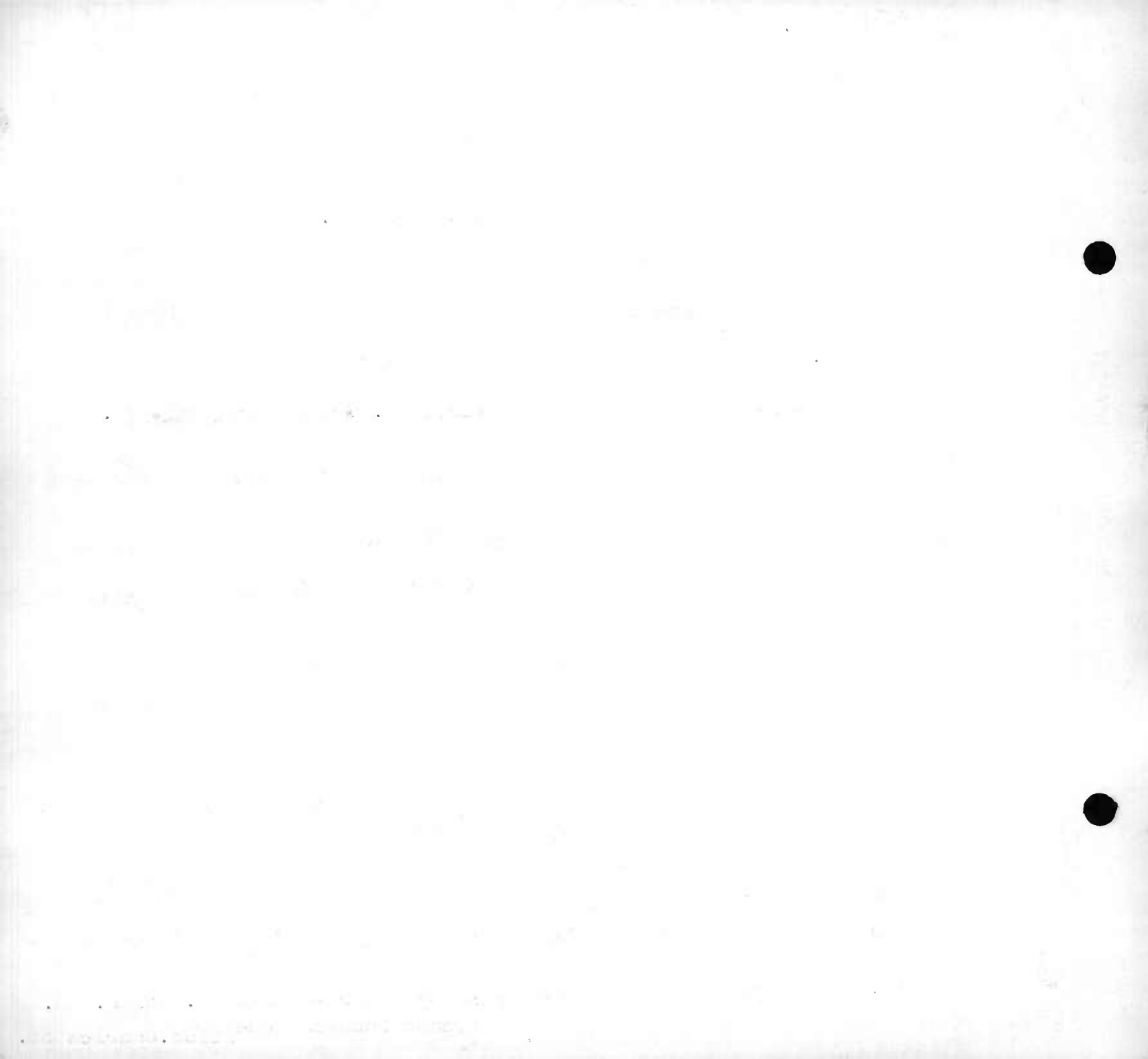
419 Chapler Oak Ave.

1-11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

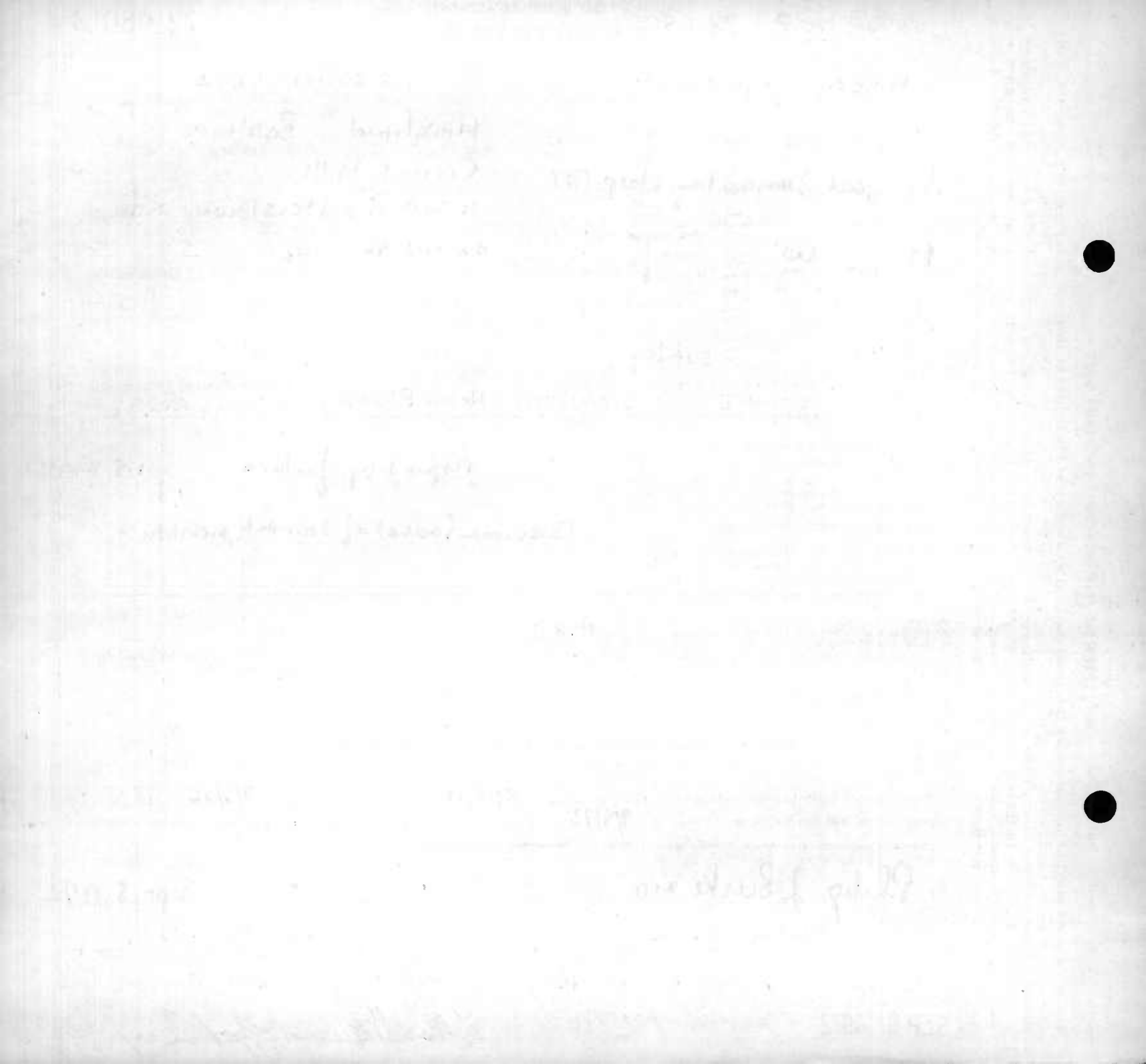
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |                                                                                                                                      | REG. NO. 72-18612                                                                                                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 72-18612                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |                                                                                                                                      | STATE OF MARYLAND - DEATH                                                                                                                                   |  |
| BIRTH NO. <u>D-250</u>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 1. NAME OF DECEASED<br>(Type or Print) <u>MARIE DEEGAN</u>                                             |                                                                                                                                      | 2. DATE AND HOUR OF DEATH<br><u>9-5-72 1225 P.M.</u>                                                                                                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Ashburton Nursing Home, Inc</u><br><u>90</u>                                                                                                                                                                                                                      |  |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD</u><br>B. COUNTY <u>2404</u> |                                                                                                                                                             |  |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. RACE <u>WH</u>                                                                                      |                                                                                                                                      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>2-15-92</u>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 9. AGE (In years last birthday) <u>80</u>                                                              |                                                                                                                                      | 10. If Under 1 Yr. Months: Days: Hours: Min.                                                                                                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Housewife</u>                                                                                |                                                                                                                                                             |  |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                           |                                                                                                                                                             |  |
| 13. FATHER'S NAME<br><u>John W. Slane</u>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        | 14. MOTHER'S MAIDEN NAME<br><u>Jane Tully</u>                                                                                        |                                                                                                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>                                                                                                                                                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO.<br><u>none</u>                                                                 |                                                                                                                                      | 17. INFORMANT<br><u>Charles J. Deegan 1704 Belt St.</u>                                                                                                     |  |
| 18. <u>412.2 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>Cerebral Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Hypertensive CV disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>arteriosclerosis generalized</u> |  |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>None</u><br><u>years</u><br><u>years</u>                                          |                                                                                                                                                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |                                                                                                                                      |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                      | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                                                                                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                       |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> 19 <u>71</u> to <u>9/5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/5</u> 19 <u>72</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                            |  |                                                                                                        |                                                                                                                                      |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                                                                                      | 23B. DATE SIGNED<br><u>9/6/72</u>                                                                                                                           |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23D. ADDRESS                                                                                           |                                                                                                                                      | 23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                            |  |
| <u>ALAN H. MAEHT MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | <u>2 E Paul St Balto Md 21002</u>                                                                      |                                                                                                                                      |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                        |  | 24B. DATE                                                                                              |                                                                                                                                      | 24C. NAME OF CEMETERY or CREMATORY                                                                                                                          |  |
| <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | <u>9/8/72</u>                                                                                          |                                                                                                                                      | <u>Sacred Heart Cemetery</u>                                                                                                                                |  |
| 24D. LOCATION (City, town, or county)                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24E. LOCATION (City, town, or county)                                                                  |                                                                                                                                      | 24F. LOCATION (City, town, or county)                                                                                                                       |  |
| <u>Balto. Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | <u>Balto. Md.</u>                                                                                      |                                                                                                                                      | <u>Balto. Md.</u>                                                                                                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR                                                                                 |                                                                                                                                      | 25C. FUNERAL DIRECTOR ADDRESS                                                                                                                               |  |
| <u>SEP 8 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | <u>[Signature]</u>                                                                                     |                                                                                                                                      | <u>Krause Funeral Home 1216 S. Charles St.</u>                                                                                                              |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |  |                                                                  |                                                                                                                                              |                                                                                   |                                                                                               |                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------|--|
| B-240<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                         |                     | 72 08613                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                 |                                                                                                                                              | REG. NO. 72 08613                                                                 |                                                                                               | STATE OF MARYLAND-DEMH                        |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>HERBERT BIEAKLEY</b>                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                             |  |                                                                  | 2. DATE AND HOUR OF DEATH<br><b>2:30 AM 9/5/72</b>                                                                                           |                                                                                   |                                                                                               |                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                             |  |                                                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |                                                                                   |                                                                                               |                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>The Good Samaritan Hospital</b>                                                                                                                                                                                            |                     |                                                                                                                                                             |  |                                                                  | C. CITY OR TOWN<br><b>Owings Mills</b>                                                                                                       |                                                                                   | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                               |  |
|                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |  |                                                                  | E. STREET AND NUMBER<br><b>11210 Reisterstown Rd</b>                                                                                         |                                                                                   |                                                                                               |                                               |  |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                         | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>02-02-96</b>                              | 9. AGE (In years last birthday)<br><b>76</b>                                                                                                 | If Under 1 Yr. Months: Days: Hours: Min.                                          |                                                                                               | If Under 24 Hrs. Min.                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>                                                                                                                                                                                                                              |                     |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>             |                                                                                                                                              | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                      |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>Samuel Bleakley</b>                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Marshall</b>                 |                                                                                                                                              |                                                                                   |                                                                                               |                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes W.W.I</b>                                                                                                                                                                                                               |                     |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br><b>213-01-7590</b>                    |                                                                                                                                              | 17. INFORMANT<br><b>Helen Bleakley</b>                                            |                                                                                               |                                               |  |
|                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |  | ADDRESS<br><b>11210 Reisterstown Rd. Owings Mills, Md.</b>       |                                                                                                                                              |                                                                                   |                                                                                               |                                               |  |
| 18. <b>151.9</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Respiratory failure</b>                                                                                           |                     |                                                                                                                                                             |  |                                                                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Respiratory failure</b>                                          |                                                                                   |                                                                                               |                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Carcinoma (adenos) of stomach, metastatic</b>                                                                                                                                                         |                     |                                                                                                                                                             |  |                                                                  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Carcinoma (adenos) of stomach, metastatic</b>                                                      |                                                                                   |                                                                                               |                                               |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>ASHD</b>                                                                                                                                                                                            |                     |                                                                                                                                                             |  |                                                                  |                                                                                                                                              |                                                                                   |                                                                                               |                                               |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                         |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                       |                                                                                   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>NO</b>             |                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                      |                     | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)                                                                    |  |                                                                  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                  |                                                                                   |                                                                                               |                                               |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                               |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  |                                                                  | 21F. HOW DID INJURY OCCUR?                                                                                                                   |                                                                                   |                                                                                               |                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/15/72</b> 19 to <b>9/5/72</b> 19, that (I) (we) lost saw the deceased alive on <b>9/5/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death. |                     |                                                                                                                                                             |  |                                                                  |                                                                                                                                              |                                                                                   |                                                                                               |                                               |  |
| 23A. SIGNATURE<br><b>Philip J. Burke MD</b>                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  |                                                                  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>              |                                                                                   |                                                                                               | 23B. DATE SIGNED<br><b>Sept 5, 1972</b>       |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Philip Burke</b>                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |  |                                                                  | 23D. ADDRESS<br><b>Good Samaritan Hospital</b>                                                                                               |                                                                                   |                                                                                               |                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                  |                     | 24B. DATE<br><b>Sept 8, 1972</b>                                                                                                                            |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>LAKE VIEW MEM. GAR.</b> |                                                                                                                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Sykesville, Carroll, Ind.</b> |                                                                                               |                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 8 1972</b>                                                                                                                                                                                                                                                                                       |                     | 25B. NAME OF REGISTRAR<br><b>Sidney Johnson</b>                                                                                                             |  | 25C. FUNERAL DIRECTOR<br><b>Edmund J. Burke</b>                  |                                                                                                                                              | ADDRESS<br><b>11210 Reisterstown Rd. Owings Mills, Md.</b>                        |                                                                                               |                                               |  |

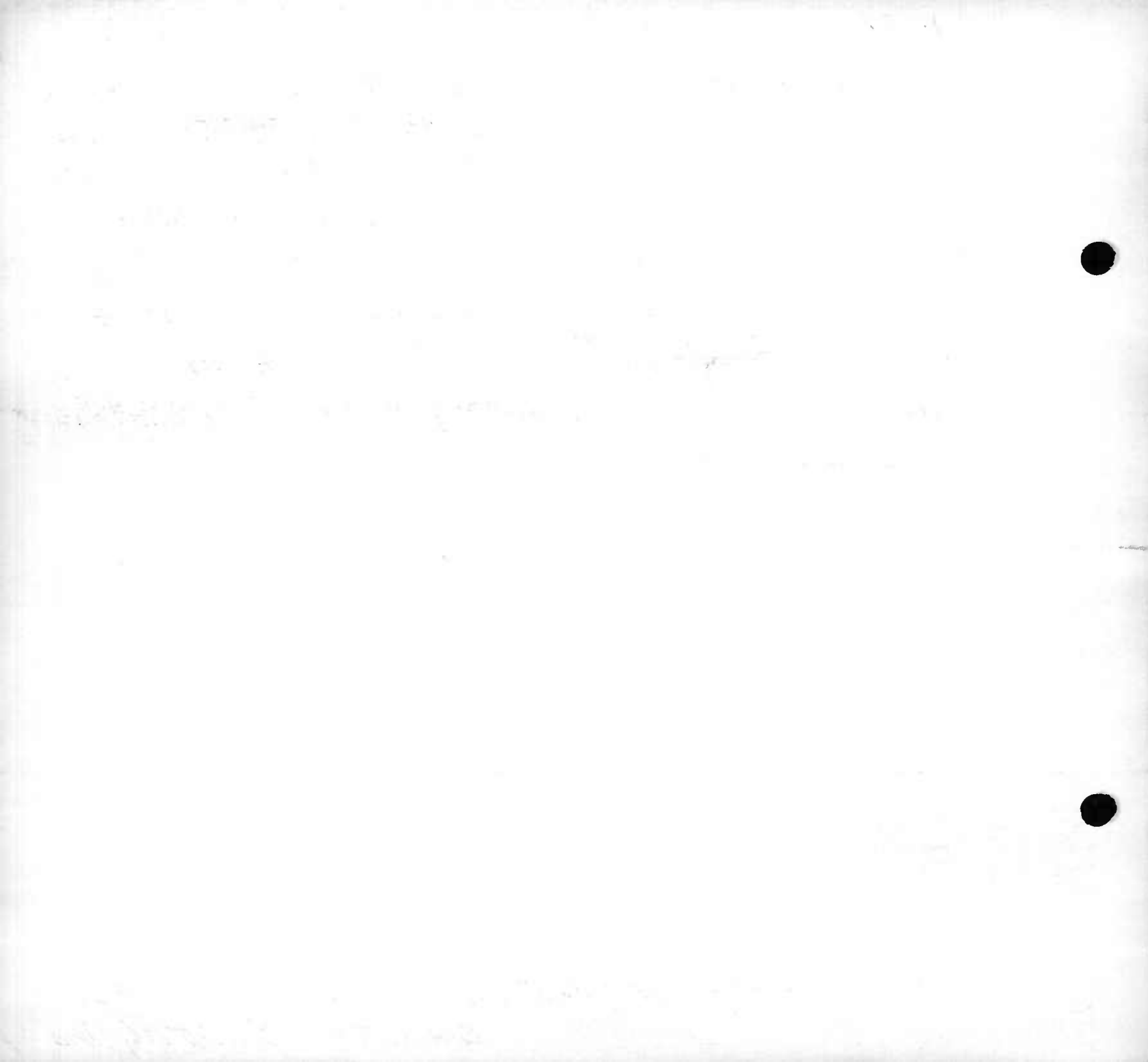




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                          |                                                                                                                                | X                                                                                   |                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------|
| 72 08614                                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                          |                                                                                                                                | 72 08614                                                                            |                                       |
| BIRTH NO. 0-354                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                          |                                                                                                                                | REG. NO. 72 08614                                                                   |                                       |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mrs. Lillian E. O'Donnell</i>                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                          | 2. DATE AND HOUR OF DEATH<br><i>9-3-72</i> <i>4:29</i> M.                                                                      |                                                                                     |                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                          | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                          |                                                                                     |                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Bon Secours Hosp.</i><br><i>BALTO, Md.</i>                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                          | A. STATE <i>Md.</i> B. COUNTY <i>Howard</i>                                                                                    |                                                                                     |                                       |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                          | C. CITY OR TOWN <i>ELICOTT CITY</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                     |                                       |
|                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                          | E. STREET AND NUMBER <i>10377 Lombard Dr. 6300</i>                                                                             |                                                                                     |                                       |
| 5. SEX <i>FEMALE</i>                                                                                                                                                                                                                                                                                                                                     | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>4-15-93</i>                                                                                                | 9. AGE (In years last birthday) <i>79</i>                                           | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>                                                                                                                                                                                                                                               |                  | 10B. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>                                                                                                       |                                                                                                                                | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>                           |                                       |
| 13. FATHER'S NAME <i>GIDEON BROSEYNE</i>                                                                                                                                                                                                                                                                                                                 |                  | 14. MOTHER'S MAIDEN NAME <i>ADA H. ISAACSON</i>                                                                                                          |                                                                                                                                |                                                                                     |                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>                                                                                                                                                                                                                                       |                  | 16. SOCIAL SECURITY NO. <i>212 74 1602</i>                                                                                                               |                                                                                                                                | 17. INFORMANT <i>NANCY SAMPSON</i> ADDRESS <i>9 Shadybrook Ave. Balto, Md 21228</i> |                                       |
| 18. <i>410.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                          | CAUSE OF DEATH                                                                                                                 |                                                                                     |                                       |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                              |                  |                                                                                                                                                          | (A) IMMEDIATE CAUSE <i>Myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                            |                                                                                     |                                       |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                          | (B) <i>ASCVD</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                            |                                                                                     |                                       |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                |                  |                                                                                                                                                          | (C) _____                                                                                                                      |                                                                                     |                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                   |                  |                                                                                                                                                          |                                                                                                                                |                                                                                     |                                       |
| 19A. DATE OF OPERATION <i>0</i>                                                                                                                                                                                                                                                                                                                          |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                                                                                | 20A. AUTOPSY? (Yes or No) <i>No</i>                                                 |                                       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                                                                                                                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                                       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                |                                                                                                                                | 21F. HOW DID INJURY OCCUR?                                                          |                                       |
| 22. I certify that (I) (this hospital) attended the deceased from <i>SEP 3 morning 1972</i> to <i>SEP 3 7:30 PM 1972</i> that (I) (we) last saw the deceased alive on <i>SEP 3 7:30 PM 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                          |                                                                                                                                |                                                                                     |                                       |
| 23A. SIGNATURE <i>CHOON JA AHN</i>                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                          |                                                                                                                                | 23B. DATE SIGNED <i>SEP 3 7:30 PM 72</i>                                            |                                       |
| 23C. PHYSICIAN'S NAME (Type) <i>CHOON JA AHN</i>                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                          |                                                                                                                                | 23D. ADDRESS <i>Bon Secours</i>                                                     |                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>                                                                                                                                                                                                                                                                                                   |                  | 24B. DATE <i>9-7-72</i>                                                                                                                                  |                                                                                                                                | 24C. NAME OF CEMETERY OR CREMATORY <i>NEW Cathedral</i>                             |                                       |
| 24D. LOCATION (City, town, or county) <i>BALTO</i>                                                                                                                                                                                                                                                                                                       |                  | 24E. STATE <i>Md.</i>                                                                                                                                    |                                                                                                                                | 24F. ADDRESS                                                                        |                                       |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 8 1972</i>                                                                                                                                                                                                                                                                                                        |                  | 25B. NAME OF REGISTRAR <i>Shirley Whitman</i>                                                                                                            |                                                                                                                                | 25C. FUNERAL DIRECTOR <i>SHOCK AHN</i> ADDRESS <i>ELICOTT City, Md.</i>             |                                       |



1

M-241

72 08615

STATE OF MARYLAND - DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT

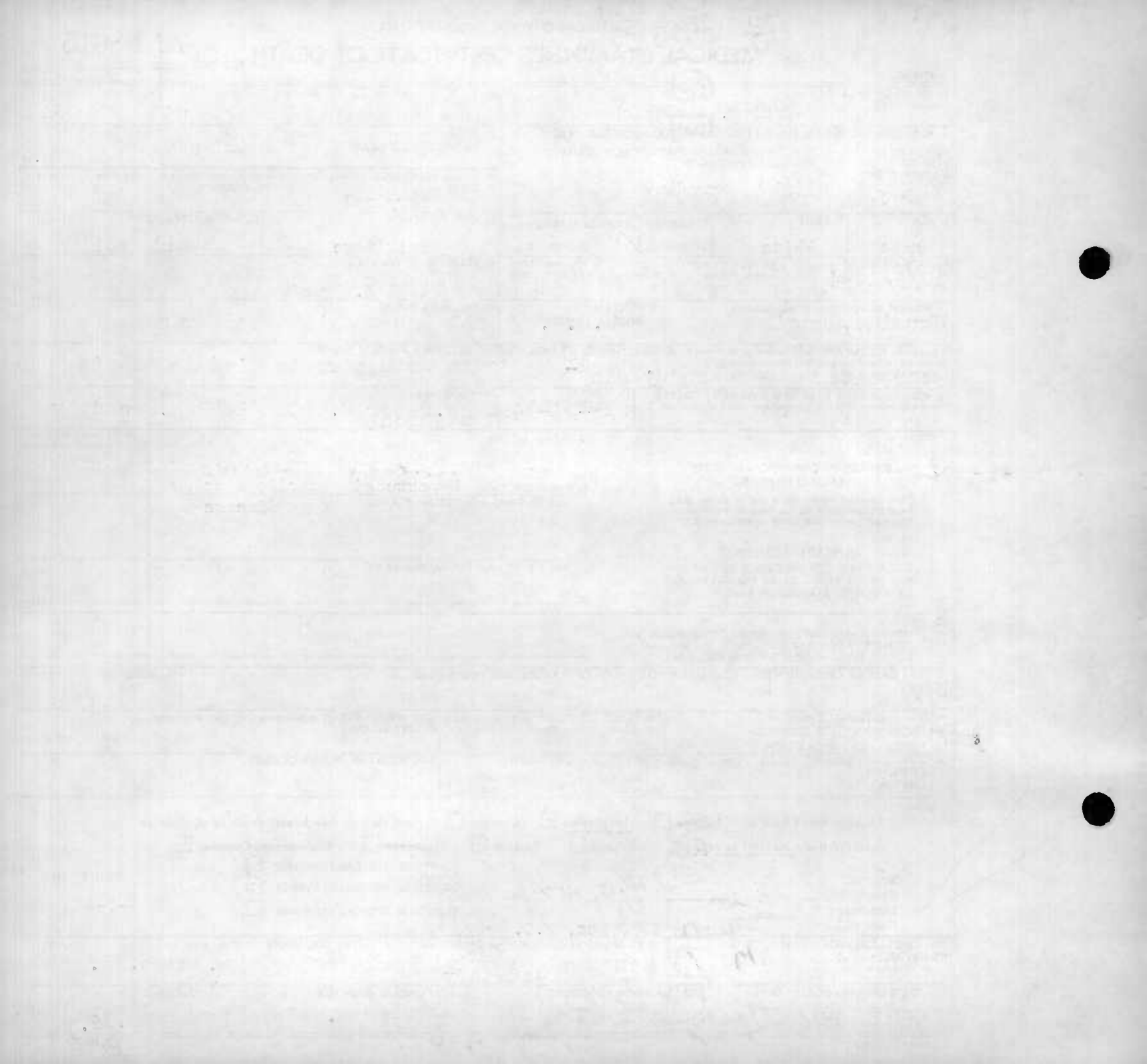
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08615

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Paul L. Mislovich                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br>9 7 72 11:15A M.                                                           |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1601 N. Broadway                                                                                                                                                                                                                                                                                                               |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 7 72 11:15A M.                                                                                                                                    |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7. RACE<br>White                                                                                                                                                                                      |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                                                          |  |
| 9. DATE OF BIRTH<br>10/3/1894                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (in years lost birthday)<br>78                                                                                                                                                                |  |
| 11. BIRTHPLACE (State or foreign country)<br>Ukraine, Russia                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. CITIZEN OF<br>WHAT COUNTRY?<br>Ukraine                                                                                                                                                            |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>carpenter                                                                                                                                                                                                                                                                                                                                                                                                  |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Beth Steel shipyards                                                                                                                                             |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                           |  | 17. SOCIAL SECURITY NO.<br>215-61-3458                                                                                                                                                                |  |
| 18. INFORMANT<br>Mr. Peter D. Katan stepson                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | ADDRESS<br>1601 N. Broadway                                                                                                                                                                           |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                          |  |
| 20A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                      |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                     |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                              |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br>m. _____                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                             |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                              |  |
| 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Marvin S. Platt, M.D.              |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br><br>DATE SIGNED<br>9-7-72 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>burial                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24B. DATE<br>9/9/1972                                                                                                                                                                                 |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Moreland Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24D. LOCATION (City, town, or county) (State)<br>Taylor Ave. Balto, Md.                                                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 8 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 25B. NAME OF REGISTRAR<br>A. J. [Signature]                                                                                                                                                           |  |
| 25C. FUNERAL DIRECTOR<br>Charles D. Sadowski                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | ADDRESS<br>Gough St. Balto. Md.                                                                                                                                                                       |  |

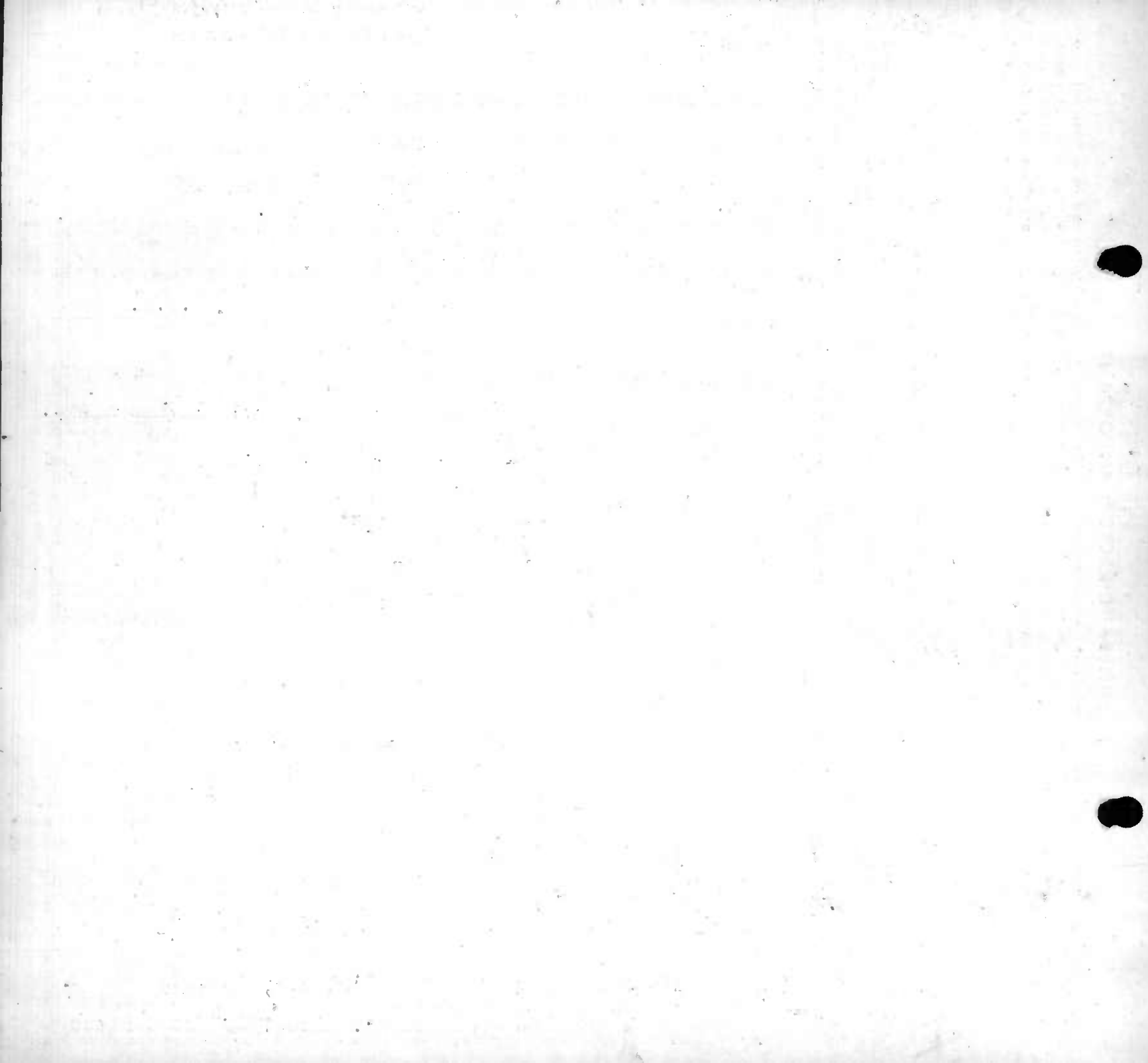
VS 151-REV. 7/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

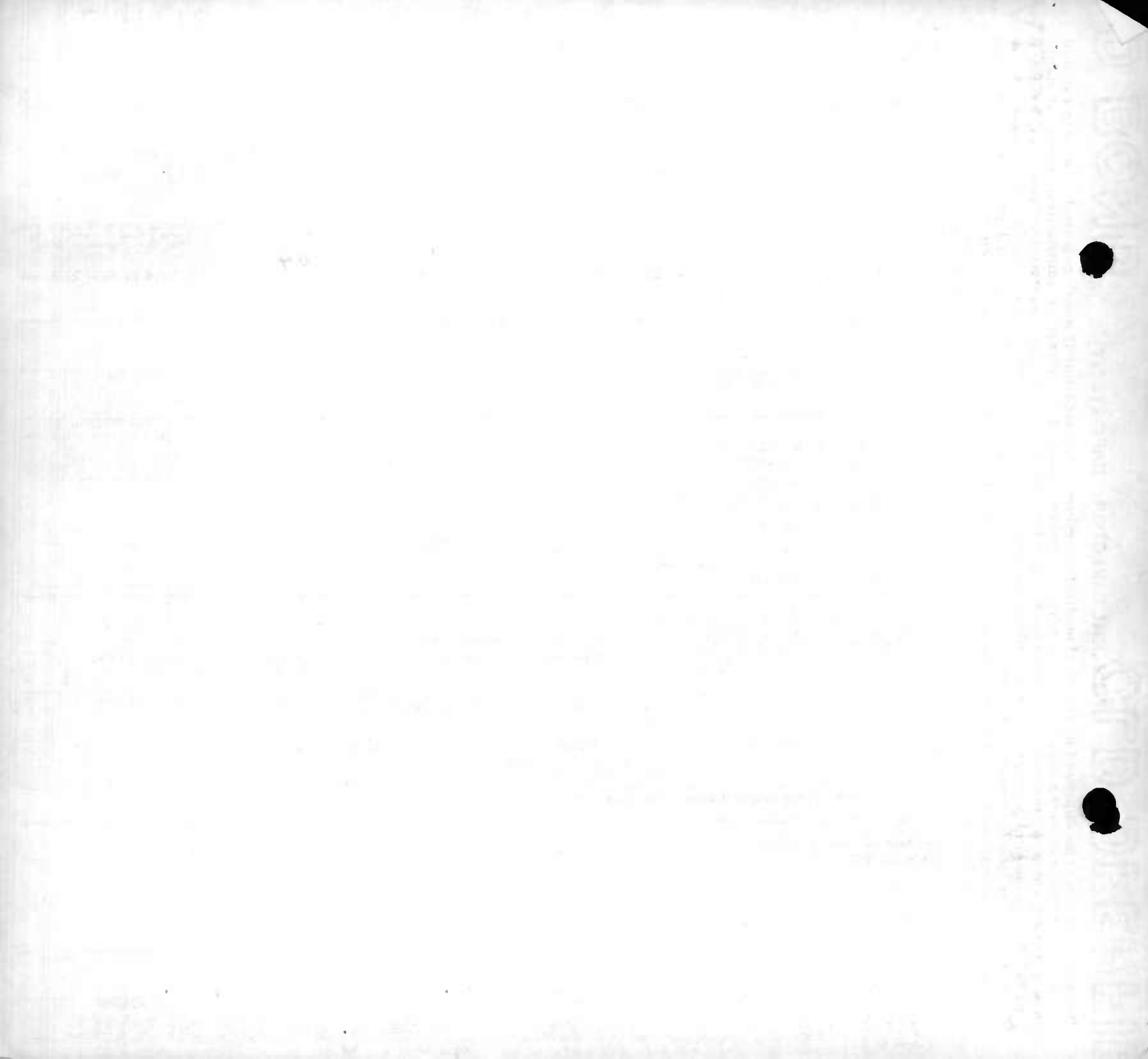
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  |                                                                                       |                       |                                                                      |                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------|------------------------|
| 5-520                                                                                                                                                                                                                                                                                              |         | 72 08616                                                                                |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                       | 72 08616                                                             |                        |
| BIRTH NO.                                                                                                                                                                                                                                                                                          |         |                                                                                         |                  | REG. NO.                                                                              |                       |                                                                      |                        |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                             |         |                                                                                         |                  | 2. DATE AND HOUR OF DEATH                                                             |                       |                                                                      |                        |
| Mack Sims                                                                                                                                                                                                                                                                                          |         |                                                                                         |                  | 8/29/72                                                                               |                       |                                                                      |                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                             |         |                                                                                         |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) |                       |                                                                      |                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                       |         |                                                                                         |                  | A. STATE                                                                              |                       | B. COUNTY                                                            |                        |
| 3410 Powhatan Ave.                                                                                                                                                                                                                                                                                 |         |                                                                                         |                  | Maryland                                                                              |                       | 1538                                                                 |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  | C. CITY OR TOWN                                                                       |                       | D. INSIDE CITY LIMITS?                                               |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  | Baltimore                                                                             |                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  | E. STREET AND NUMBER                                                                  |                       |                                                                      |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  | 3410 Powhatan Ave.                                                                    |                       |                                                                      |                        |
| 5. SEX                                                                                                                                                                                                                                                                                             | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>              | 8. DATE OF BIRTH | 9. AGE (In years lost birthday)                                                       | If Under 1 Yr. Months | If Under 24 Hrs. Days                                                | If Under 24 Hrs. Hours |
| M                                                                                                                                                                                                                                                                                                  | C       | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>           | 2/28/88          | 84                                                                                    |                       |                                                                      |                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                        |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                       |                  | 11. BIRTHPLACE (State or foreign country)                                             |                       | 12. CITIZEN OF WHAT COUNTRY?                                         |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  | Georgia                                                                               |                       | U.S.A.                                                               |                        |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                  |         |                                                                                         |                  | 14. MOTHER'S MAIDEN NAME                                                              |                       |                                                                      |                        |
| Henry Sims                                                                                                                                                                                                                                                                                         |         |                                                                                         |                  | Alice Jeames                                                                          |                       |                                                                      |                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                           |         | 16. SOCIAL SECURITY NO.                                                                 |                  | 17. INFORMANT                                                                         |                       | ADDRESS                                                              |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  | Henry Thomas Sims                                                                     |                       | 3410 Powhatan Ave.                                                   |                        |
| No. 404X I                                                                                                                                                                                                                                                                                         |         |                                                                                         |                  | CAUSE OF DEATH                                                                        |                       |                                                                      |                        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                     |         |                                                                                         |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |                       |                                                                      |                        |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                       |         |                                                                                         |                  | Respiratory failure                                                                   |                       |                                                                      |                        |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                  |         |                                                                                         |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |                       |                                                                      |                        |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                          |         |                                                                                         |                  | Hypertension and Coronary Artery Disease                                              |                       |                                                                      |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  | (C) Final Cause                                                                       |                       |                                                                      |                        |
| II                                                                                                                                                                                                                                                                                                 |         |                                                                                         |                  |                                                                                       |                       |                                                                      |                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                   |         |                                                                                         |                  |                                                                                       |                       |                                                                      |                        |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                             |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                        |                  | 20A. AUTOPSY? (Yes or No)                                                             |                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  |                                                                                       |                       |                                                                      |                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                              |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                       |                                                                      |                        |
|                                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  |                                                                                       |                       |                                                                      |                        |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                      |         | 21E. INJURY OCCURRED                                                                    |                  | 21F. HOW DID INJURY OCCUR?                                                            |                       |                                                                      |                        |
|                                                                                                                                                                                                                                                                                                    |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |                  |                                                                                       |                       |                                                                      |                        |
| 22. I certify that (I) (this hospital) attended the deceased from 8/29/72 to 8/29/72, that (I) (we) last saw the deceased alive on 8/29/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. |         |                                                                                         |                  |                                                                                       |                       |                                                                      |                        |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                     |         |                                                                                         |                  | 23B. DATE SIGNED                                                                      |                       |                                                                      |                        |
| S. Shorofsky                                                                                                                                                                                                                                                                                       |         |                                                                                         |                  | 8/31/72                                                                               |                       |                                                                      |                        |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                       |         |                                                                                         |                  | 23D. ADDRESS                                                                          |                       |                                                                      |                        |
| S. Shorofsky                                                                                                                                                                                                                                                                                       |         |                                                                                         |                  | 4734 PARKWAY                                                                          |                       | 21215                                                                |                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                           |         | 24B. DATE                                                                               |                  | 24C. NAME OF CEMETERY or CREMATORY                                                    |                       | 24D. LOCATION (City, town, or county) (State)                        |                        |
| Burial                                                                                                                                                                                                                                                                                             |         | 9/1/72                                                                                  |                  | Arbutus Memorial Park                                                                 |                       | Arbutus, Maryland                                                    |                        |
| 25A. DATE REC'D BY HEALTH DEPT                                                                                                                                                                                                                                                                     |         | 25B. NAME OF REGISTRAR                                                                  |                  | 25C. FUNERAL DIRECTOR                                                                 |                       | ADDRESS                                                              |                        |
| SEP 8 1972                                                                                                                                                                                                                                                                                         |         | Sidney W. Brown                                                                         |                  | Charles A. Rice                                                                       |                       | 1300 Eutaw Place                                                     |                        |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                  |                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. <b>4-230</b>                                                                                                                                                                                                                                                                                                                        |                      | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                      |                                  | REG. NO. <b>72 08617</b>                                                                         |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LAURA HAZET</b>                                                                                                                                                                                                                                                                                     |                      | 2. DATE AND HOUR OF DEATH<br><b>9/2/72</b> <b>6:10 P.M.</b>                                                                                                                                                                                                                                                           |                                  |                                                                                                  |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>48 MARYLAND GEN. HOSPITAL<br/>827 LINDEN AVE.<br/>BALTO. MD 21201</b>                                                                                           |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>21217</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>572 LAUREL ST.</b> |                                  |                                                                                                  |                                                        |
| 5. SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                          | 6. RACE <b>BLACK</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                           | 8. DATE OF BIRTH <b>12/16/07</b> | 9. AGE (In years last birthday) <b>64</b>                                                        | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC WORK</b>                                                                                                                                                                                                                              |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                     |                                  | 11. BIRTHPLACE (State or foreign country) <b>LOUISIANA</b>                                       |                                                        |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>                                                                                                                                                                                                                                                                                                  |                      | 13. FATHER'S NAME <b>Betteas</b>                                                                                                                                                                                                                                                                                      |                                  | 14. MOTHER'S MAIDEN NAME <b>BETSY HAZET</b>                                                      |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>                                                                                                                                                                                                                            |                      | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                               |                                  | 17. INFORMANT <b>DAUGHTER</b> ADDRESS <b>BALTO. MD. 1625 VINCENT COURT</b><br><b>ANNIE HENRY</b> |                                                        |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>412.41 + 250.9</b>                                                                                                                   |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiopulmonary arrest</b><br>(B) <b>Disease</b><br>(C) <b>Arteriosclerotic cardiovascular</b>                                                                                                                                               |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>about 3-4 hrs.</b>                            |                                                        |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                |                      | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Diabetes Mellitus</b>                                                                                                                                                          |                                  | years                                                                                            |                                                        |
| 19A. DATE OF OPERATION <b>2</b>                                                                                                                                                                                                                                                                                                               |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                      |                                  | 20A. AUTOPSY? (Yes or No) <b>YES</b>                                                             |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Inotify medical examiner                                                                                                                                                                                                                                 |                      | 21B. PLACE OF INJURY (e.g., in or about home, lawn, factory, street, office bldg., etc.)                                                                                                                                                                                                                              |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                         |                                                        |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                     |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                             |                                  | 21F. HOW DID INJURY OCCUR?                                                                       |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 2, 1972</b> to <b>Sept. 2, 1972</b> and that (I) (we) lost saw the deceased alive on <b>Sept. 2, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                  |                                                        |
| 23A. SIGNATURE <b>[Signature]</b>                                                                                                                                                                                                                                                                                                             |                      | 23B. DATE SIGNED <b>9/2/72</b>                                                                                                                                                                                                                                                                                        |                                  | 23C. PHYSICIAN'S NAME (Type) <b>RT MACCARI</b>                                                   |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                        |                      | 24B. DATE <b>9/6/72</b>                                                                                                                                                                                                                                                                                               |                                  | 24C. NAME of CEMETERY or CREMATORY <b>Mount Calvary Cem.</b>                                     |                                                        |
| 24D. LOCATION (City, town, or county) <b>Brooklyn, Md.</b>                                                                                                                                                                                                                                                                                    |                      | 24E. STATE <b>BALTO. MD 21201</b>                                                                                                                                                                                                                                                                                     |                                  | 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 8 1972</b>                                                |                                                        |
| 25B. NAME OF REGISTRAR <b>[Signature]</b>                                                                                                                                                                                                                                                                                                     |                      | 25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>                                                                                                                                                                                                                                                                          |                                  | 25D. ADDRESS <b>1300 Eutaw Place</b>                                                             |                                                        |





1

72 08618

STATE OF MARYLAND-DHMH

BALTIMORE CITY HEALTH DEPARTMENT

72 08618

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Carolyn Savage</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month <b>8</b> Day <b>29</b> Year <b>72</b> Hour <b>4:53</b> p. M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 2312 Norfolk St.</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                   |  | 3. DATE PRONOUNCED DEAD<br>Month <b>8</b> Day <b>29</b> Year <b>72</b> Hour <b>4:53</b> p. M.                                                                            |  |
| 6. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br><b>Negro</b>                                                                                                                                                  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | C. CITY OR TOWN<br><b>Balto.</b>                                                                                                                                         |  |
| 9. DATE OF BIRTH<br><b>10/29/45</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10. AGE (In years last birthday)<br><b>26</b>                                                                                                                            |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                                             |  |
| 13. FATHER'S NAME<br><b>Ernest Hawkins</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Beatrice Savage</b>                                                     |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Beatrice Savage</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                  |  |
| 17. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 18. INFORMANT<br><b>Beatrice Savage 1839 Pressman St.</b>                                                                                                                |  |
| 19. CAUSE OF DEATH<br><b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) IMMEDIATE CAUSE<br/>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                     |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                 |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 23.                                                                                                                                                                      |  |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                                                                              |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| ACTUAL SIGNATURE<br><b>Peter Lipkovic, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | DATE SIGNED<br><b>8/30/72</b>                                                                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><b>10/5/72</b>                                                                                                                                              |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Auburn Cem.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24D. LOCATION (City, town, or county) (State)<br><b>Westport, Maryland</b>                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 8 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR<br><b>Adrian H. Hinton</b>                                                                                                                        |  |
| 25C. FUNERAL DIRECTOR<br><b>Charles A. Rice</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br><b>1300 Eutaw Place</b>                                                                                                                                       |  |

VS 151-REV. 1/1/68

11-2-1972 - Completion of cause of death on a pending medical examiner death certificate -  
Peter Lipkovic, M.D. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

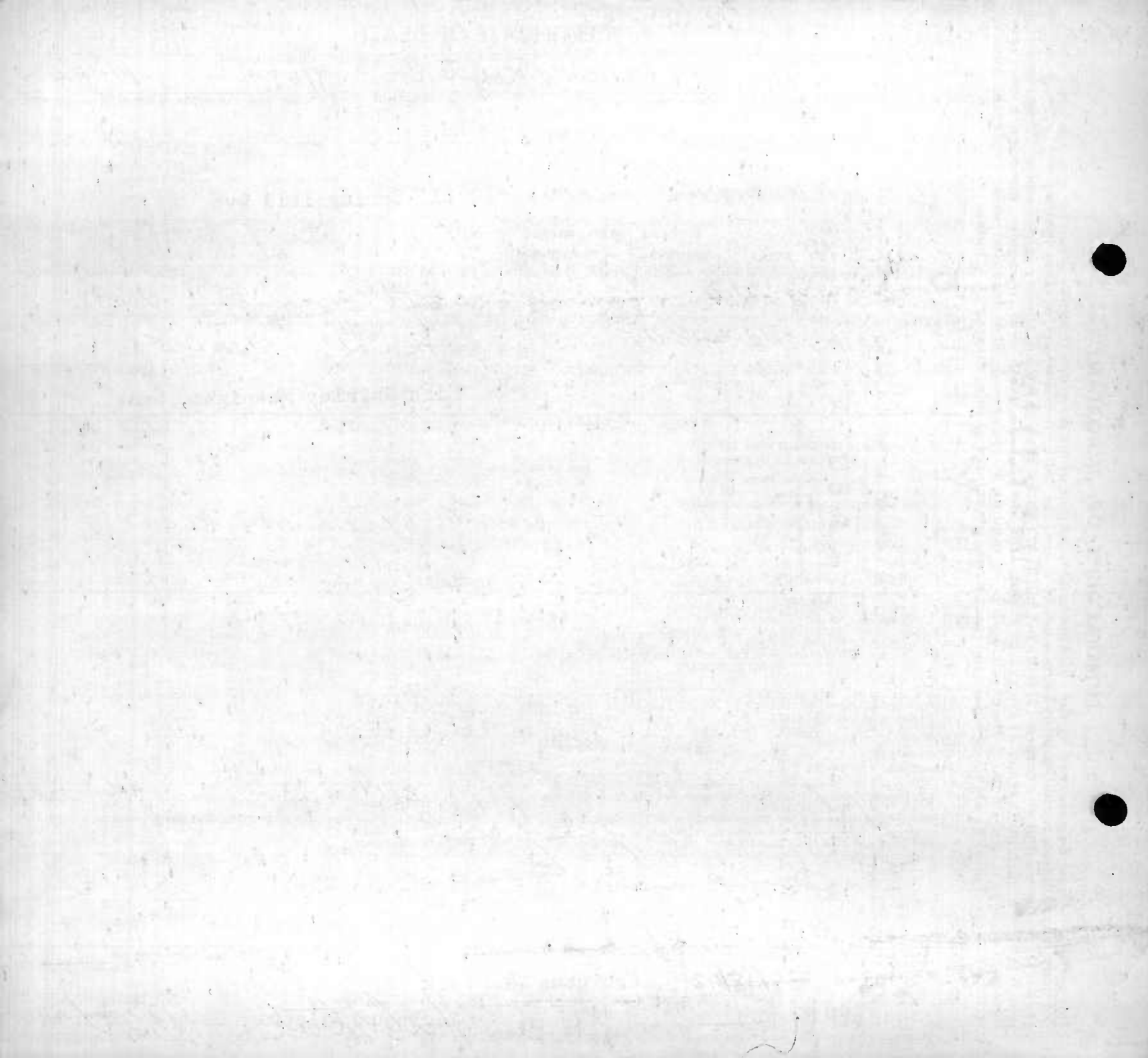
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                                                                                                                                                                                                    |                                    | REG. NO. <u>72 08619</u><br>STATE OF MARYLAND - DHMH                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------|
| B-320 72 08619<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                                                                                                                                                                                                    |                                    |                                                                                                        |
| 1. NAME OF DECEASED<br>(Type or Print)<br><u>Boots, Elsie</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      | 2. DATE AND HOUR OF DEATH<br><u>9/3/72 8:05 P.M.</u>                                                                                                                                                                                                                                                                               |                                    |                                                                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Lutheran Hospital</u><br><u>46 230 Ashbactor Street</u><br><u>Baltimore, Md. 21216</u>                                                                                                                                                                                                                                                   |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>1607</u><br>C. CITY OR TOWN <u>Baltimore</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>1634 N. Ellamont Street</u> |                                    |                                                                                                        |
| 5. SEX <u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE <u>Black</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                        | 8. DATE OF BIRTH<br><u>8-05-03</u> | 9. AGE (In years last birthday) <u>69</u><br>If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                  |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                           |
| 13. FATHER'S NAME<br><u>Joseph Boardley</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 14. MOTHER'S MAIDEN NAME<br><u>Irene Hardman</u>                                                                                                                                                                                                                                                                                   |                                    |                                                                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                                                                                                                                                                                  |                      | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                            |                                    | 17. INFORMANT<br><u>Ernest Boots</u> ADDRESS<br><u>1634 N. Ellamont St.</u>                            |
| 18. <u>427.9 I</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>(A) IMMEDIATE CAUSE Pulmonary Embolism</u><br><u>(B) Cardiac Irregularity</u><br><u>(C)</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |                                                                                                                                                                                                                                                                                                                                    |                                    |                                                                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                                                                                                                                                                                                    |                                    |                                                                                                        |
| 19A. DATE OF OPERATION<br><u>9</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                   |                                    | 20A. AUTOPSY? (Yes or No)                                                                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                           |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><u>9-3-72</u>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                          |                                    | 21F. HOW DID INJURY OCCUR?                                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-1-72</u> to <u>9-3-72</u> that (I) (we) last saw the deceased alive on <u>9-3-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                   |                      |                                                                                                                                                                                                                                                                                                                                    |                                    |                                                                                                        |
| 23A. SIGNATURE<br><u>Louderes M. Victoria</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      | 23B. DATE SIGNED<br><u>9-3-72</u>                                                                                                                                                                                                                                                                                                  |                                    | 23C. PHYSICIAN'S NAME (Type)<br><u>LOURDES M. VICTORIA</u>                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 24B. DATE<br><u>9/7/72</u>                                                                                                                                                                                                                                                                                                         |                                    | 24C. NAME of CEMETERY or CREMATORY<br><u>Mt. Calvary Cemetery</u>                                      |
| 24D. LOCATION (City, town, or county) (State)<br><u>Brooklyn, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 25A. DATE REC'D. BY HEALTH DEPT.<br><u>SEP 8 1972</u>                                                                                                                                                                                                                                                                              |                                    |                                                                                                        |
| 25B. NAME OF REGISTRAR<br><u>Ernest Boots</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      | 25C. FUNERAL DIRECTOR<br><u>Charles A. Rice</u> ADDRESS<br><u>1300 N. Eutaw Pl.</u>                                                                                                                                                                                                                                                |                                    |                                                                                                        |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 72 08620                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                       |  | REG. NO. 72 08620                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | STATE OF MARYLAND-DMH                                                                                                                                                  |  |                                                                       |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>LILLY McKNIGHT Royster</i>                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><i>9/6/72 10-P.M.</i>                                                                                                                     |  |                                                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                                                                  |  |                                                                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>44 UNION MEMORIAL HOSPITAL</i>                                                                                                                                                                                                                                                                                 |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                      |  | A. STATE<br><i>Md</i>                                                                                                                                                  |  | B. COUNTY<br><i>2710</i>                                              |  |
| 5. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                   |  | 6. RACE<br><i>Negro</i>                                                                                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  | 8. DATE OF BIRTH<br><i>2/10/26</i>                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>SOCIAL SERVICE WORKER</i>                                                                                                                                                                                                                               |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                         |  | 9. AGE (In years last birthday)<br><i>46</i>                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><i>NORTH CAROLINA</i>    |  |
| 13. FATHER'S NAME<br><i>JOHN MCKNIGHT</i>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>                                                                                                                           |  |                                                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                  |  |                                                                                                           |  | 16. SOCIAL SECURITY NO.                                                                                                                                                |  | 17. INFORMANT<br><i>Miss Shirley McKnight, Smae</i>                   |  |
| 18. <i>250.91</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                                                                                                           |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br><i>DIABETES, HYPERTENSION, CVA</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                                        |  |                                                                       |  |
| 19A. DATE OF OPERATION<br><i>D</i>                                                                                                                                                                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                              |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                     |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                            |  |                                                                       |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                 |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                             |  |                                                                       |  |
| 22. I certify that (1) (this hospital) attended the deceased from <i>8/11/72</i> to <i>9/6/72</i> , that (1) (we) last saw the deceased alive on <i>9/6/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.                                   |  |                                                                                                           |  |                                                                                                                                                                        |  |                                                                       |  |
| 23A. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                        |  | 23B. DATE SIGNED<br><i>9/6/72</i>                                     |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>DR. RUFARZ</i>                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 23D. ADDRESS<br><i>UNION MEMORIAL HOSPITAL</i>                                                                                                                         |  |                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                 |  | 24B. DATE<br><i>9/12/72</i>                                                                               |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Arbutus Mem Park</i>                                                                                                          |  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 8 1972</i>                                                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR<br><i>[Signature]</i>                                                              |  | 25C. FUNERAL DIRECTOR<br><i>[Signature]</i>                                                                                                                            |  | ADDRESS<br><i>1206 W North Ave</i>                                    |  |

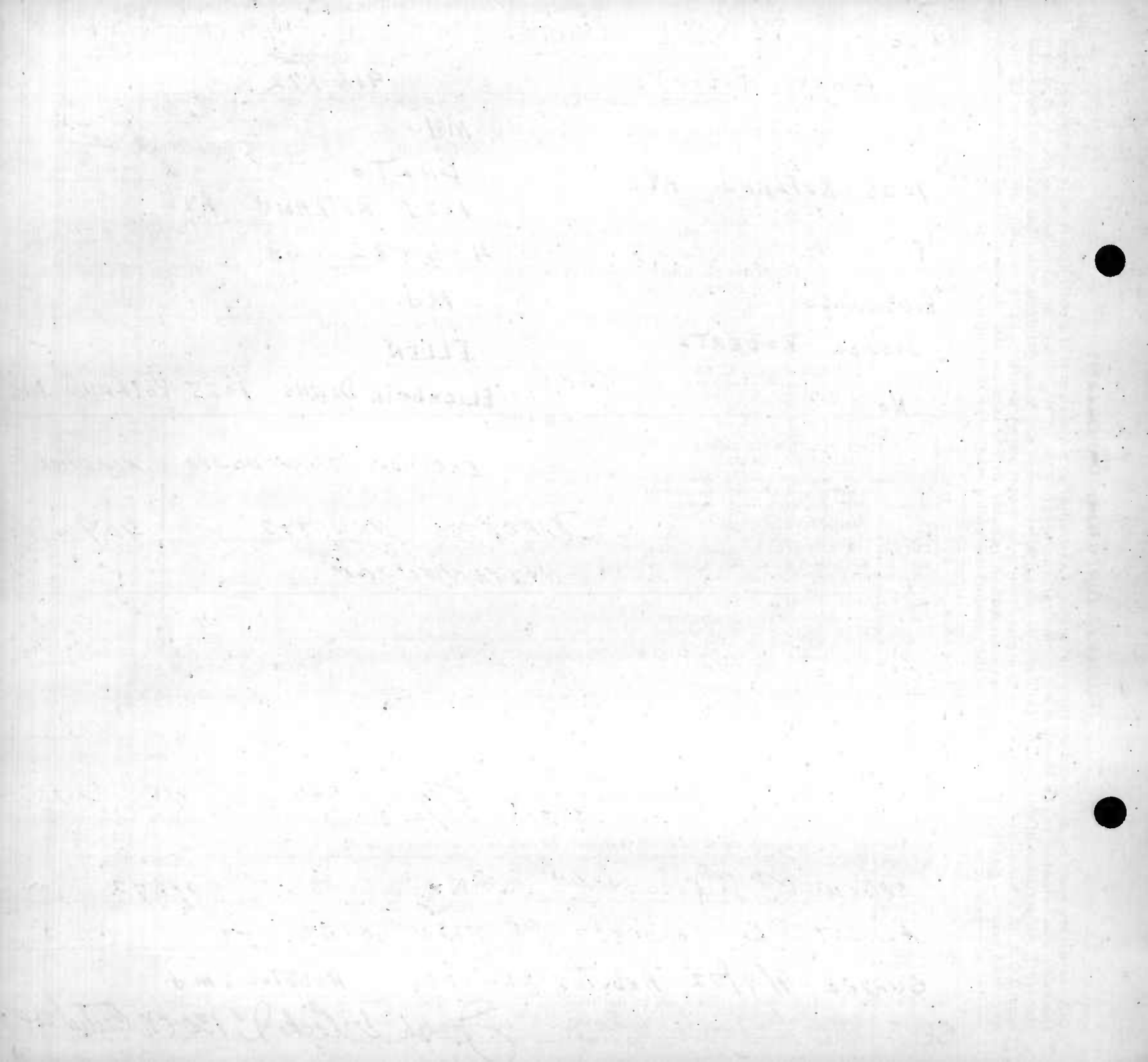


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                                                                                                                                                                                    | REG. NO. 72 08621                                                        |                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| 72 08621                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                                                                                                                                                                                    | STATE OF MARYLAND-DHMT                                                   |                                                           |
| BIRTH NO. <b>R-163</b>                                                                                                                                                                                                                                                                                                                                 |                  | 72 08621                                                                                                                                                    |                                                                                                                                                                                                    | STATE OF MARYLAND-DHMT                                                   |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY Roberts</b>                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>9/6/72</b>                                                                                                                                                         |                                                                          |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                              |                                                                          |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1025 RUTLAND AVE</b>                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             | A. STATE <b>MD</b><br>B. COUNTY <b>808</b>                                                                                                                                                         |                                                                          |                                                           |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             | C. CITY OR TOWN <b>BALTO.</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                                                          |                                                           |
|                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             | E. STREET AND NUMBER <b>1025 RUTLAND AVE</b>                                                                                                                                                       |                                                                          |                                                           |
| 5. SEX <b>F.</b>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <b>E</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>4-6-82</b>                                                                                                                                                                     | 9. AGE (In years last birthday) <b>90</b>                                | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                        |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                                                                    | 11. BIRTHPLACE (State or foreign country) <b>MD.</b>                     |                                                           |
| 13. FATHER'S NAME<br><b>Joseph ROBERTS</b>                                                                                                                                                                                                                                                                                                             |                  | 14. MOTHER'S MAIDEN NAME<br><b>ELLEN</b>                                                                                                                    |                                                                                                                                                                                                    |                                                                          |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                  |                  | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                                                                                                                                                                                    | 17. INFORMANT ADDRESS<br><b>ELIZABETH DOWNS 1025 RUTLAND AVE</b>         |                                                           |
| 18. <b>250.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>II</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.          |                  |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>CORONARY THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>DIABETES MELLITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>MYOPARTEN 30N</b> |                                                                          |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                   |                                                                          |                                                           |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                               |                                                                          |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                              |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                    | 21F. HOW DID INJURY OCCUR?                                               |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>5/11</b> 19 <b>60</b> to <b>9/6</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>8/31</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                                                                                                                                                                                                    |                                                                          |                                                           |
| 23A. SIGNATURE<br><b>Robert R. Roberts MD</b>                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             |                                                                                                                                                                                                    | 23B. DATE SIGNED<br><b>9/8/72</b>                                        |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ALBERT L. LAFOREST MD</b>                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             |                                                                                                                                                                                                    | 23D. ADDRESS<br><b>822A. BOND ST</b>                                     |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                              |                  | 24B. DATE<br><b>9/9/72</b>                                                                                                                                  |                                                                                                                                                                                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEM. PK</b>             |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>ARBUTUS, MD</b>                                                                                                                                                                                                                                                                                    |                  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 8 1972</b>                                                                                                        |                                                                                                                                                                                                    |                                                                          |                                                           |
| 25B. NAME OF REGISTRAR<br><b>Joseph Roberts</b>                                                                                                                                                                                                                                                                                                        |                  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>1304 N. Central Ave</b>                                                                                                 |                                                                                                                                                                                                    |                                                                          |                                                           |







| B-200 72 08622                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                      |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                           |  |                                                                                                              |  | 72 08622                                                                                      |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                      |  |                                                                                                                                                                                            |  |                                                                                                              |  | REG. NO.                                                                                      |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANTON BASCH</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                      |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Month Day Year                                                                     |  |                                                                                                              |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>September 6, 1972 12:35 A.</b>                |  |  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MARYLAND GENERAL HOSPITAL</b>                                                                                                                                                                                                                                               |  |                                                                                                                      |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1205</b>                                                    |  |                                                                                                              |  |                                                                                               |  |  |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 7. RACE<br><b>White</b>                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                          |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 9. DATE OF BIRTH<br><b>Sept. 1, 1908</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 10. AGE (In years last birthday) <b>64</b>                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                |  | E. STREET AND NUMBER<br><b>1723 St. Paul Street</b>                                           |  |  |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Meat Cutter Ret.</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                      |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME<br><b>Marie Kolleck</b>                                                             |  |                                                                                               |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                      |  | 17. SOCIAL SECURITY NO.<br><b>217-05-7745</b>                                                                                                                                              |  | 18. INFORMANT<br><b>Matthew J. Basch</b>                                                                     |  | ADDRESS <b>Calif. 92653</b>                                                                   |  |  |  |
| 19. <b>E 887X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                        |  |                                                                                                                      |  | CAUSE OF DEATH<br><b>Subdural Hematoma</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |                                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                           |  |                                                                                                                      |  |                                                                                                                                                                                            |  |                                                                                                              |  |                                                                                               |  |  |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                           |  |                                                                                                              |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                        |  |  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                  |  |                                                                                                                      |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                                                                                    |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>1723 St. Paul Street 1205</b> |  |                                                                                               |  |  |  |
| 22D. TIME (Month) (Day) (Year) (Hour)<br>(APPROX.) <b>9-4-72 5:30 P. m.</b>                                                                                                                                                                                                                                                                                                                                      |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?<br><b>Fell at home</b>                                                                                                                                          |  |                                                                                                              |  |                                                                                               |  |  |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                      |  |                                                                                                                                                                                            |  |                                                                                                              |  |                                                                                               |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>W P Mulloy</b><br><b>William P. Mulloy, M.D.</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                      |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                   |  |                                                                                                              |  | DATE SIGNED<br><b>9/6/72</b>                                                                  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                        |  | 24B. DATE<br><b>9/7/72</b>                                                                                           |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Parkwood Cemetery</b>                                                                                                                             |  | 24D. LOCATION (City, town, or county) (State)<br><b>Parkville Baltimore Md.</b>                              |  |                                                                                               |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 8 1972</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                      |  | 25B. NAME OF REGISTRAR<br><b>Sidney Johnson</b>                                                                                                                                            |  | 25C. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home</b>                                                         |  | ADDRESS<br><b>7401 Belair Rd. Balto. 21236</b>                                                |  |  |  |

WASHINGTON, D. C.

TO THE SECRETARY OF THE INTERIOR

FROM THE CHIEF OF BUREAU

SUBJECT

RE: [illegible]

DATE

RECEIVED

1911

FILE

1911

1911

1911

WILLIAM F. [illegible]  
[illegible]

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Walter Clinton Sykes                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br>September 5, 1972 10:30 P. M.                                                     |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>UNIVERSITY HOSPITAL (DOA)                                                                                                                                                                                                                                                                                 |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>September 5, 1972 10:30 P. M.                                                                                                                   |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7. RACE<br>Negro                                                                                                                                                                                  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>separated                                                                                                                                                                                                                                                                                                            |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                                                      |  |
| 9. DATE OF BIRTH<br>7-4-1903                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10. AGE (In years lost birthday)<br>69                                                                                                                                                            |  |
| 11. BIRTHPLACE (State or foreign country)<br>Virginia                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                               |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>manager                                                                                                                                                                                                                                                                                                                                                                               |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Store                                                                                                                                                        |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.<br>218-18-4182                                                                                                                                                            |  |
| 18. INFORMANT<br>Mr. Leroy Arrungton Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS<br>3309 Virginia A                                                                                                                                                                        |  |
| 19. E 965X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Gunshot wound of chest                                                                                                                                                                                                                                                |  | CAUSE OF DEATH<br>Gunshot wound of chest                                                                                                                                                          |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                      |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                                              |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                   |  |
| 20A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-                                                                                                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                     |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Store                                                                                                 |  |
| 22D. TIME OF INJURY (APPROX.)<br>9-5-72 10:15 P. m.                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                 |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>901 Harlem Avenue-Jumbo Ice Cream Store                                                                                                                                                                                                                                                                                                                                                                 |  | 22F. HOW DID INJURY OCCUR?<br>Shot during attempted hold-up                                                                                                                                       |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Peter Lipkovic, M.D. |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br>9/6/72 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE<br>9-10-72                                                                                                                                                                              |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Nazareth Baptist Church Cemetery                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br>Boston Virginia                                                                                                                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 8 1972                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR<br>Sidney Johnston                                                                                                                                                         |  |
| 25C. FUNERAL DIRECTOR<br>Nutter Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br>3035 W. North Av                                                                                                                                                                       |  |

*Handwritten signature*

1

J-250 72 08624 STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08624 REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>William Wilson Jackson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Hour |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>00 901 Harlem Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>September 5, 1972 10:30 P.M.                               |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7. RACE<br>Negro                                                                                             |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | C. CITY OR TOWN<br>Baltimore                                                                                 |  |
| 9. DATE OF BIRTH<br>1-15-1913                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10. AGE (In years last birthday)<br>59                                                                       |  |
| 11. BIRTHPLACE (State or foreign country)<br>Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                          |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Construction                                                            |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes World War II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 17. SOCIAL SECURITY NO.<br>579-07-6903                                                                       |  |
| 15. MOTHER'S MAIDEN NAME<br>Martha Jones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 18. INFORMANT<br>Mr. Joshua H. Jackson 3907 W. Garrison                                                      |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Gunshot wounds of chest<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                 |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Store            |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>901 Harlem Avenue - Jumbo Ice Cream                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 22D. TIME OF INJURY (APPROX.)<br>9-5-72 10:15 P.                                                             |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22F. HOW DID INJURY OCCUR?<br>Shot during attempted holdup                                                   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 9/6/72 |  |                                                                                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 24B. DATE<br>9-10-72                                                                                         |  |
| 24C. NAME of CEMETERY or CREMATORY<br>Nazareth Baptist Church Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 24D. LOCATION (City, town, or county) (State)<br>Boston Virginia                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 8 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 25B. NAME OF REGISTRAR<br>Sidney [Signature]                                                                 |  |
| 25C. FUNERAL DIRECTOR<br>NUTTER FUNERAL HOME 3035 W. NORTH AVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 25D. ADDRESS                                                                                                 |  |

VS 151-REV. 1/1/68

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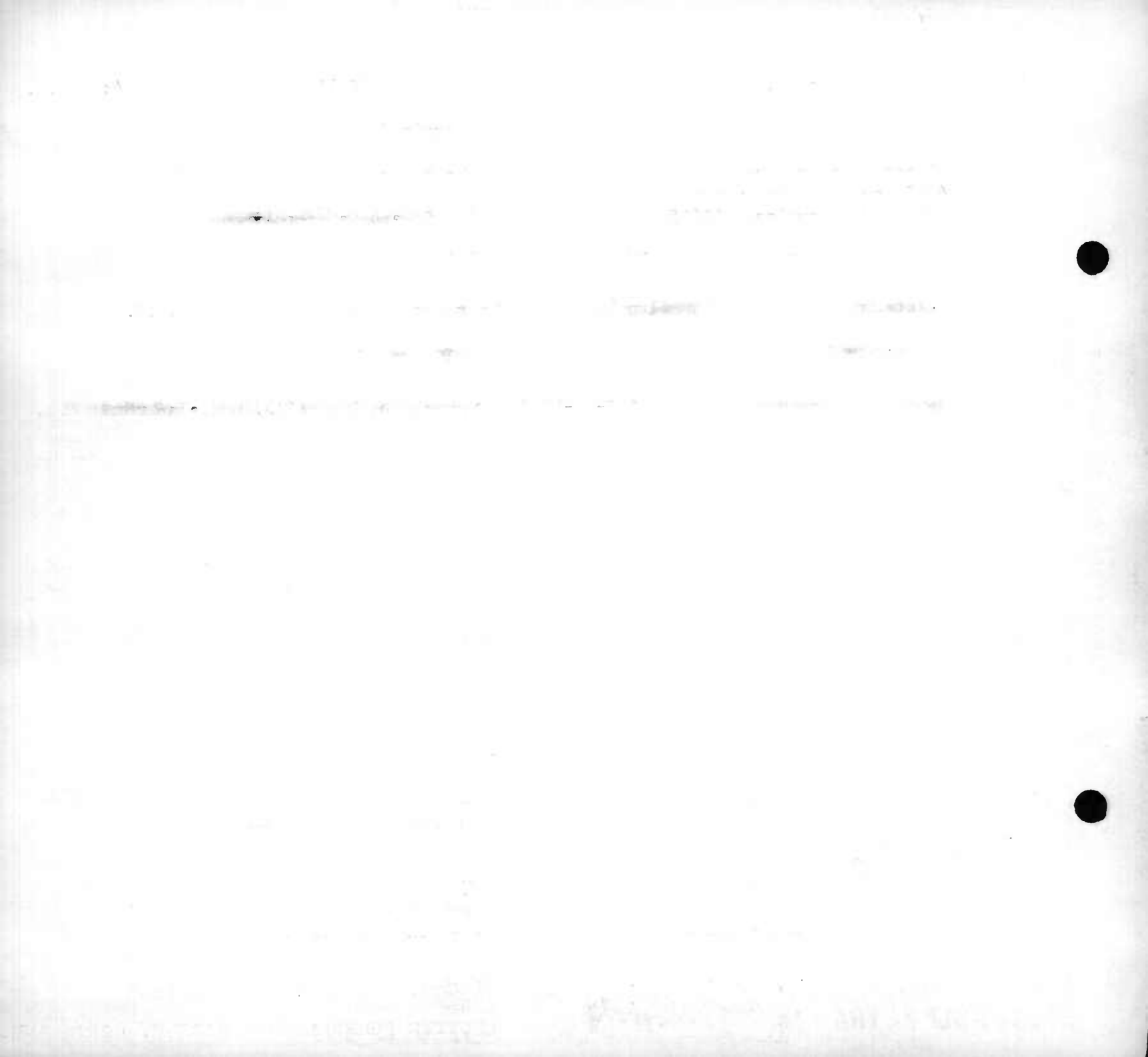
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                             |         |                                                                                          |                  | REG. NO. <u>72 08625</u>                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|
| 72 08625                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                          |                  | STATE OF MARYLAND - DEPT                                                 |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                    |         | 1. NAME OF DECEASED<br>(Type or Print)                                                   |                  | 2. DATE AND HOUR OF DEATH                                                |
|                                                                                                                                                                                                                                                                                                                                                              |         | Noah S. Hill                                                                             |                  | 9/5/72 4:00 A.M.                                                         |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                       |         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |                  |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                 |         | A. STATE B. COUNTY                                                                       |                  |                                                                          |
| Pleasant Manor Nursing Home<br>4615 Park Heights Avenue<br>Baltimore, Maryland 21215                                                                                                                                                                                                                                                                         |         | Maryland                                                                                 |                  |                                                                          |
|                                                                                                                                                                                                                                                                                                                                                              |         | C. CITY OR TOWN                                                                          |                  | D. INSIDE CITY LIMITS?                                                   |
|                                                                                                                                                                                                                                                                                                                                                              |         | Baltimore                                                                                |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
|                                                                                                                                                                                                                                                                                                                                                              |         | E. STREET AND NUMBER                                                                     |                  |                                                                          |
|                                                                                                                                                                                                                                                                                                                                                              |         | 1614 E. Biddle Street                                                                    |                  |                                                                          |
| 5. SEX                                                                                                                                                                                                                                                                                                                                                       | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                          |
| Male                                                                                                                                                                                                                                                                                                                                                         | Negro   | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>            | 11/29/81         | 90                                                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                  |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                  | 11. BIRTHPLACE (State or foreign country)                                |
| custodian                                                                                                                                                                                                                                                                                                                                                    |         | Hutzler's Dept. Store Maryland                                                           |                  | 12. CITIZEN OF WHAT COUNTRY?                                             |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                            |         | 14. MOTHER'S MAIDEN NAME                                                                 |                  |                                                                          |
| John Hill                                                                                                                                                                                                                                                                                                                                                    |         | ? ?                                                                                      |                  |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                     |         | 16. SOCIAL SECURITY NO.                                                                  |                  | 17. INFORMANT ADDRESS                                                    |
| No                                                                                                                                                                                                                                                                                                                                                           |         | 215-09-2585                                                                              |                  | Mrs. Cora Jones 2312 N. Rosedale St.                                     |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                           |         | CAUSE OF DEATH                                                                           |                  |                                                                          |
| 250-71                                                                                                                                                                                                                                                                                                                                                       |         | antipneumatic Heart Disease                                                              |                  |                                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                            |         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                   |                  |                                                                          |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                    |         | Diabetes mellitus                                                                        |                  |                                                                          |
|                                                                                                                                                                                                                                                                                                                                                              |         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |                  |                                                                          |
|                                                                                                                                                                                                                                                                                                                                                              |         | Chronic Bronch Syndrome                                                                  |                  |                                                                          |
|                                                                                                                                                                                                                                                                                                                                                              |         | (C)                                                                                      |                  |                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                             |         |                                                                                          |                  |                                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                |
| 0                                                                                                                                                                                                                                                                                                                                                            |         |                                                                                          |                  | no                                                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                        |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.)                                                                                                                                                                                                                                                                                                                                |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                               |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                  |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |                                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 27</u> 19 <u>72</u> to <u>Sept 5</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Sept 5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                          |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                               |         | 23B. DATE SIGNED                                                                         |                  |                                                                          |
| Manuel Levin MD                                                                                                                                                                                                                                                                                                                                              |         | 9/5/72                                                                                   |                  |                                                                          |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                 |         | 23D. ADDRESS                                                                             |                  |                                                                          |
| Manuel Levin                                                                                                                                                                                                                                                                                                                                                 |         | 6101 Park Heights Avenue Balto Md                                                        |                  |                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                     |         | 24B. DATE                                                                                |                  | 24C. NAME of CEMETERY or CREMATORY                                       |
| Burial                                                                                                                                                                                                                                                                                                                                                       |         | 9-9-1972                                                                                 |                  | Maryland National Cem.                                                   |
|                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                          |                  | Laurel Maryland                                                          |
| 25A. DATE RECD. BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                              |         | 25B. NAME OF FUNERAL HOME                                                                |                  | 25C. FUNERAL DIRECTOR ADDRESS                                            |
| SEP 8 1972                                                                                                                                                                                                                                                                                                                                                   |         | Nutter Funeral Home                                                                      |                  | 3035 W. NORTH AVE.                                                       |

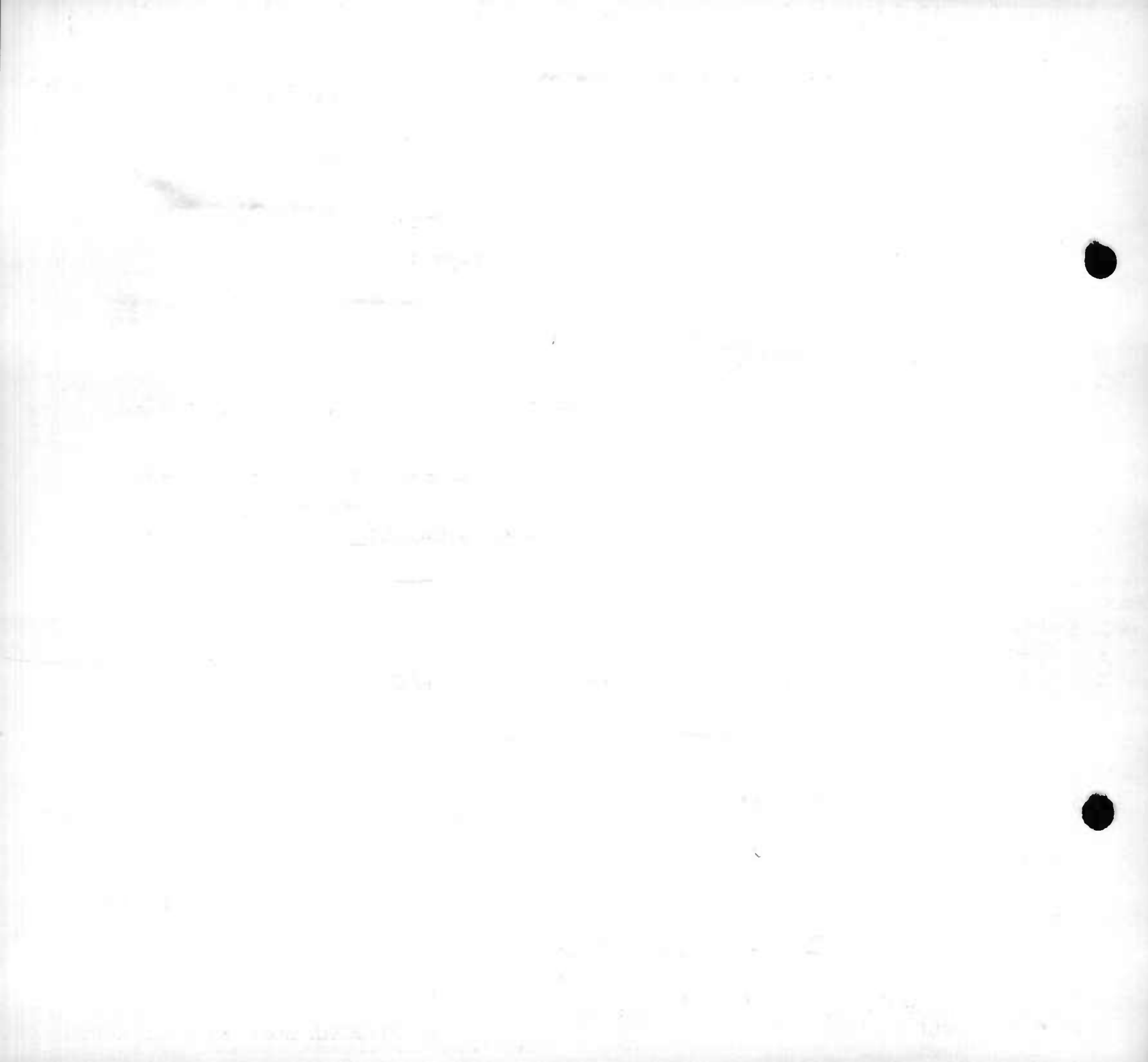




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                         |  |  |  | 72 08626                                                                                                                         |  | 72 08626 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------|--|
| BIRTH NO.                                                                                                                                                |  |  |  | REG. NO.                                                                                                                         |  |          |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                   |  |  |  | 2. DATE AND HOUR OF DEATH                                                                                                        |  |          |  |
| Louise S. Jackson                                                                                                                                        |  |  |  | 9/7/72 2:30 AM                                                                                                                   |  |          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)                                             |  |          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                |  |  |  | A. STATE B. COUNTY                                                                                                               |  |          |  |
| Lutheran Hospital                                                                                                                                        |  |  |  | Maryland                                                                                                                         |  |          |  |
| 5. SEX                                                                                                                                                   |  |  |  | 6. RACE                                                                                                                          |  |          |  |
| Female                                                                                                                                                   |  |  |  | Negro                                                                                                                            |  |          |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 8. DATE OF BIRTH                                                                                                                 |  |          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                              |  |  |  | 9. AGE (In years last birthday)                                                                                                  |  |          |  |
| Domestic                                                                                                                                                 |  |  |  | 11-27-1885 87                                                                                                                    |  |          |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |  |  |  | 11. BIRTHPLACE (State or foreign country)                                                                                        |  |          |  |
| Pvt. Family                                                                                                                                              |  |  |  | West Indies                                                                                                                      |  |          |  |
| 13. FATHER'S NAME                                                                                                                                        |  |  |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                     |  |          |  |
| Roderick Scotland                                                                                                                                        |  |  |  | USA                                                                                                                              |  |          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                 |  |  |  | 16. SOCIAL SECURITY NO.                                                                                                          |  |          |  |
| No                                                                                                                                                       |  |  |  | 212-56-2546                                                                                                                      |  |          |  |
| 17. INFORMANT                                                                                                                                            |  |  |  | ADDRESS                                                                                                                          |  |          |  |
| Miss Fern Scotland                                                                                                                                       |  |  |  | 1942 Edmondson Ave.                                                                                                              |  |          |  |
| 18. CAUSE OF DEATH                                                                                                                                       |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                     |  |          |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                           |  |  |  | (A) IMMEDIATE CAUSE                                                                                                              |  |          |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)             |  |  |  | CEREBRO VASCULAR                                                                                                                 |  |          |  |
| ANTECEDENT CAUSES                                                                                                                                        |  |  |  | DUE TO, OR AS A CONSEQUENCE OF:                                                                                                  |  |          |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                |  |  |  | ACCIDENT                                                                                                                         |  |          |  |
| (B) Atherosclerotic heart disease.                                                                                                                       |  |  |  | DUE TO, OR AS A CONSEQUENCE OF:                                                                                                  |  |          |  |
| (C)                                                                                                                                                      |  |  |  | DUE TO, OR AS A CONSEQUENCE OF:                                                                                                  |  |          |  |
| II                                                                                                                                                       |  |  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |          |  |
| 19A. DATE OF OPERATION                                                                                                                                   |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  |          |  |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                |  |  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                             |  |          |  |
| NO.                                                                                                                                                      |  |  |  | NO.                                                                                                                              |  |          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                    |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                         |  |          |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |  |  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                  |  |          |  |
| 21E. INJURY OCCURRED                                                                                                                                     |  |  |  | 21F. HOW DID INJURY OCCUR?                                                                                                       |  |          |  |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                        |  |  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                |  |          |  |
| 22. I certify that (I) (this hospital) attended the deceased from                                                                                        |  |  |  | 9/4/72 to 9/7/72                                                                                                                 |  |          |  |
| that (I) (we) lost saw the deceased alive on                                                                                                             |  |  |  | 19 and that in (my) (our) opinion death occurred on the date                                                                     |  |          |  |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                           |  |  |  | 23A. SIGNATURE                                                                                                                   |  |          |  |
| 23B. DATE SIGNED                                                                                                                                         |  |  |  | 9/7/72                                                                                                                           |  |          |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                             |  |  |  | 23D. ADDRESS                                                                                                                     |  |          |  |
| E. SANDOZ, M.D.                                                                                                                                          |  |  |  | NUTTER FUNERAL HOME 3035 W. NORTH AVE.                                                                                           |  |          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                 |  |  |  | 24B. DATE                                                                                                                        |  |          |  |
| Burial                                                                                                                                                   |  |  |  | 9-11-72                                                                                                                          |  |          |  |
| 24C. NAME OF CEMETERY or CREMATORY                                                                                                                       |  |  |  | 24D. LOCATION (City, town, or county) (State)                                                                                    |  |          |  |
| Arbutus Memorial Park                                                                                                                                    |  |  |  | Baltimore Co., Maryland                                                                                                          |  |          |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                          |  |  |  | 25C. FUNERAL DIRECTOR                                                                                                            |  |          |  |
| SEP 8 1972                                                                                                                                               |  |  |  | NUTTER FUNERAL HOME 3035 W. NORTH AVE.                                                                                           |  |          |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             |                            |                                                                                               |                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------|
| C-636 72 08627                                                                                                                                                                                                                                                                                   |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                            | REG. NO. 72 08627                                                                             |                                                            |
| BIRTH NO.                                                                                                                                                                                                                                                                                        |                  | CERTIFICATE OF DEATH                                                                                                                                        |                            | STATE OF MARYLAND-DMHE                                                                        |                                                            |
| 1. NAME OF DECEASED<br>(Type or Print) JOHN J. CARTER                                                                                                                                                                                                                                            |                  | 2. DATE AND HOUR OF DEATH<br>Sept. 3, 1972 11:15 AM                                                                                                         |                            |                                                                                               |                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                           |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                       |                            |                                                                                               |                                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Provident Hospital<br>Baltimore, Md.                                                                                                                                                                                                                     |                  | A. STATE<br>Maryland                                                                                                                                        |                            | B. COUNTY<br>1547                                                                             |                                                            |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                             |                  | C. CITY OR TOWN<br>Baltimore                                                                                                                                |                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                            |
|                                                                                                                                                                                                                                                                                                  |                  | E. STREET AND NUMBER<br>3022 Windsor Ave.                                                                                                                   |                            |                                                                                               |                                                            |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                   | 6. RACE<br>NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>7/5/95 | 9. AGE (In years last birthday)<br>77                                                         | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                                                                                                           |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Amer. Sugar Refinery                                                                                                   |                            | 11. BIRTHPLACE (State or foreign country)<br>Virginia                                         |                                                            |
| 13. FATHER'S NAME<br>George Carter                                                                                                                                                                                                                                                               |                  | 14. MOTHER'S MAIDEN NAME<br>Adelaid Braxton                                                                                                                 |                            |                                                                                               |                                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes 1917, 1918 + 1919                                                                                                                                                                |                  | 16. SOCIAL SECURITY NO.                                                                                                                                     |                            | 17. INFORMANT<br>Annie S. Carter 3022 Windsor Ave                                             |                                                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>486X                                                                                       |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Aspiration Pneumonia (Terminal)                                                    |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>16 hours                                      |                                                            |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                   |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                            | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                           |                                                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Cerebral Thromboses                                                                                                                                    |                  |                                                                                                                                                             |                            | 1961 + 7/2/72                                                                                 |                                                            |
| 19A. DATE OF OPERATION<br>none                                                                                                                                                                                                                                                                   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                            | 20A. AUTOPSY? (Yes or No)<br>no                                                               |                                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                            |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                            |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                     |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>                                                   |                            | 21F. HOW DID INJURY OCCUR?                                                                    |                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from 7/30/72 to 9/3/72 that (I) (we) last saw the deceased alive on 9/3/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                            |                                                                                               |                                                            |
| 23A. SIGNATURE<br>D.W. STEWART, M.D.                                                                                                                                                                                                                                                             |                  | 23B. DATE SIGNED<br>9/3/72                                                                                                                                  |                            | 23C. PHYSICIAN'S NAME (Type)<br>D.W. STEWART, M.D.                                            |                                                            |
| 23D. ADDRESS<br>2300 Garrison Blvd (21216)                                                                                                                                                                                                                                                       |                  | 23E. ATTENDING PHYSICIAN<br>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                            |                                                                                               |                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                               |                  | 24B. DATE<br>9-7-72                                                                                                                                         |                            | 24C. NAME OF CEMETERY OR CREMATORY<br>Arbuzas Memorial Park                                   |                                                            |
| 24D. LOCATION<br>Baltimore Co. Maryland                                                                                                                                                                                                                                                          |                  | 24E. NAME OF REGISTRAR<br>Anthony...                                                                                                                        |                            | 24F. FUNERAL DIRECTOR<br>Nutter Funeral Home 3035 W. North Ave.                               |                                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 8 1972                                                                                                                                                                                                                                                    |                  | 25B. NAME OF REGISTRAR                                                                                                                                      |                            | 25C. FUNERAL DIRECTOR                                                                         |                                                            |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                    |                                                                                                                                         |                            |                                                                        |                             |                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------|--|
| C-410                                                                                                                                                                                                                                                                                                                                              |                         | 72 08628                                                                                                                                                    |                                    | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                        |                            | CERTIFICATE OF DEATH                                                   |                             | REG. NO. 72 08628                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                          |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>RONALD L. COLBY</b>                                                                                               |                                    |                                                                                                                                         |                            | 2. DATE AND HOUR OF DEATH<br><b>9/3/72 5:56 P.M.</b>                   |                             | STATE OF MARYLAND - DEMO                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>2759</b> |                            | C. CITY OR TOWN<br><b>BALTIMORE</b>                                    |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSP.</b>                                                                                                                                                                                                                                                                                 |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33</b>                                                                           |                                    | E. STREET AND NUMBER<br><b>1119 SPRINGFIELD AVE</b>                                                                                     |                            |                                                                        |                             |                                                                                               |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>NEGRO</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/22/89</b> | 9. AGE (In years lost birthday)<br><b>83</b>                                                                                            | If Under 1 Yr. Months Days |                                                                        | If Under 24 Hrs. Hours Min. |                                                                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TRUCK DRIVER</b>                                                                                                                                                                                                                                 |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO. TRANSFER CO.</b>                                                                                             |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>BAHAMAS</b>                                                                             |                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |                             |                                                                                               |  |
| 13. FATHER'S NAME<br><b>RONALD COLBY</b>                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                    | 14. MOTHER'S MAIDEN NAME<br><b>FRANCES COLBY</b>                                                                                        |                            |                                                                        |                             |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                              |                         | 16. SOCIAL SECURITY NO.<br><b>212-69-2692</b>                                                                                                               |                                    | 17. INFORMANT<br><b>JANET M. COLBY</b>                                                                                                  |                            | ADDRESS<br><b>1119 Springfield</b>                                     |                             |                                                                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>162.1 I</b>                                                                                                                               |                         |                                                                                                                                                             |                                    | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cardiac arrest</b>                                                            |                            |                                                                        |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min</b>                                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                    | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>C of lung</b>                                                                                 |                            |                                                                        |                             | <b>4 yrs</b>                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                    | (C) <b>Malignancy to brain</b>                                                                                                          |                            |                                                                        |                             | <b>2 yrs</b>                                                                                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Pulmonary edema</b>                                                                                                                                                                                   |                         |                                                                                                                                                             |                                    |                                                                                                                                         |                            |                                                                        |                             | <b>2 days</b>                                                                                 |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                 |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY (Yes or No)<br><b>No</b>                                                                                                   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                             |                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                                    | 21C. WHERE DID INJURY OCCUR                                                                                                             |                            | (If in Baltimore City, give exact location)                            |                             |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                      |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR                                                                                                               |                            |                                                                        |                             |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/3</b> 19 <b>72</b> to <b>9/3</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/3</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                    |                                                                                                                                         |                            |                                                                        |                             |                                                                                               |  |
| 23A. SIGNATURE<br><b>Craig T. Haytmanek, M.D.</b>                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>         |                            | 23B. DATE SIGNED<br><b>9/3/72</b>                                      |                             |                                                                                               |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CRAIG T. HAYTMANEK, M.D.</b>                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                    | 23D. ADDRESS<br><b>JOHNS HOPKINS HOSP.</b>                                                                                              |                            |                                                                        |                             |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                          |                         | 24B. DATE<br><b>9-8-72</b>                                                                                                                                  |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Arbuzus Memorial Park</b>                                                                      |                            | 24D. LOCATION (City, town, or county)<br><b>Baltimore Co. Maryland</b> |                             | 15 total                                                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 8 1972</b>                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><b>Andrew H. H. H.</b>                                                                                                            |                                    | 25C. FUNERAL DIRECTOR<br><b>Nezzer Funeral Home</b>                                                                                     |                            | ADDRESS<br><b>3035 W. North Ave.</b>                                   |                             |                                                                                               |  |

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FRANCIS J. EDWARDS

FRANCIS J. EDWARDS

FRANCIS J. EDWARDS

FRANCIS J. EDWARDS

STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

72 08629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08629  
REG. NO.

B-432

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Virginia</u> MARIE BOLDOWSKY                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year<br>August 30, 1972                                    |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Johns Hopkins Hospital (DOA)</u>                                                                                                                                                                                                                                                                            |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>August 30, 1972 12:15 P.M.                                                                                                  |  |
| 6. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7. RACE<br>White                                                                                                                                                         |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                             |  |
| 9. DATE OF BIRTH<br><u>4-6-1916</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years lost birthday)<br><u>56</u>                                                                                                                            |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                            |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Hair dresser</u>                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br><u>Daisy Rix</u>                                                                                                                             |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                     |  | 17. SOCIAL SECURITY NO.<br><u>214-01-2619</u>                                                                                                                            |  |
| 18. INFORMANT<br><u>Jacob J. Boldowsky</u>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | ADDRESS<br><u>1534 Latrobe Park Terrace</u>                                                                                                                              |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |  |
| 20A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>Home</u>                                                                  |  |
| 22D. TIME OF INJURY (APPROX.)<br>Month (Day) (Year) (Hour)<br><u>8-30-72</u> ? m.                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                     |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><u>1534 Latrobe Park Terrace</u>                                                                                                                                                                                                                                                                                                                                                                             |  | 22F. HOW DID INJURY OCCUR?<br><u>Took overdose</u>                                                                                                                       |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                            |  |                                                                                                                                                                          |  |
| ACTUAL SIGNATURE<br><u>Marvin S. Platt</u><br>EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                     |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br>August 31, 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 24B. DATE<br><u>9/2/72</u>                                                                                                                                               |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><u>Holy Cross Cemetery</u>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 8 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br><u>Audrey Whorton</u>                                                                                                                          |  |
| 25C. FUNERAL DIRECTOR<br><u>Charles L. Stevens Funeral Home, Inc.</u>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><u>1504 East Fort Avenue</u>                                                                                                                                  |  |

VS 151-REV. 1/1/68

10-12-1972 - Completion of cause of death on a pending medical examiner death certificate  
Marvin S. Platt, M.D. HRS



72 08630

BALTIMORE CITY HEALTH DEPARTMENT

72 08630

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Arthur Watkins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year<br>9 7 72<br>Hour<br>8:30A. M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1822 Penn Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>9 7 72<br>Hour<br>8:30 A. M.                                                                         |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. RACE<br>Negro                                                                                                                                  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1403                         |  |
| 9. DATE OF BIRTH<br>1907                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10. AGE (In years last b' day)<br>65                                                                                                              |  |
| 11. BIRTHPLACE (State or foreign country)<br>South Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                      |  |
| 13. FATHER'S NAME<br>Edmond Watkins                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                             |  |
| 15. MOTHER'S MAIDEN NAME<br>Lula                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                           |  |
| 17. SOCIAL SECURITY NO.<br>219-146947                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 18. INFORMANT<br>Mr Anderson, 2339 W North Ave                                                                                                    |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Squamous carcinoma of larynx<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                      |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                  |  |
| 21. AUTOPSY? (Yes or No)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                          |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                         |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22F. HOW DID INJURY OCCUR?                                                                                                                        |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>Marvin S. Platt, M.D.</i> M.D.<br>EXAMINER'S NAME (Type) Marvin S. Platt, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 9-7-72 |  |                                                                                                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24B. DATE<br>9/12/72                                                                                                                              |  |
| 24C. NAME of CEMETERY or CREMATORY<br>MT Auburn Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR<br><i>Adolphus Halstead</i>                                                                                                |  |
| 25C. FUNERAL DIRECTOR<br>Adolphus Halstead 1206 W North Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 25D. ADDRESS                                                                                                                                      |  |

1822 PENNSYLVANIA AVE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                             |  | 72 08631                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|
| 72 08631 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                             |  | REG. NO. 72 08631                                                                                            |
| BIRTH NO. <u>D-325</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Jane Dotson</u>                                                                                                                                                   |  |                                                                                                              |
| 2. DATE AND HOUR OF DEATH<br><u>9/6/72</u> <u>16:45</u> P.M.                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Maryland General Hospital</u> |  |                                                                                                              |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>AA</u><br>C. CITY OR TOWN <u>Linthicum Heights</u><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <u>8 Kingbrook Rd.</u>                                                                                                                                                                                 |  | 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   |  |                                                                                                              |
| 8. DATE OF BIRTH <u>8/9/23</u> 9. AGE (in years last birthday) <u>49</u>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.N.</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>                                               |  |                                                                                                              |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                                                                                                  |  |                                                                                                              |
| 13. FATHER'S NAME <u>Louis Feezer</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME <u>Virginia May Poole</u>                                                                                                                                                          |  |                                                                                                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16. SOCIAL SECURITY NO. <u>216-16-9805</u>                                                                                                                                                                  |  | 17. INFORMANT <u>Box 3</u> ADDRESS <u>Harmon, Md. 21077</u>                                                  |
| 18. <u>57321</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |                                                                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                 |
| 19A. DATE OF OPERATION <u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>✓</u>                                                                                                                                                   |  | 20A. AUTOPSY? (Yes or No) <u>✓</u>                                                                           |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                     |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug 31</u> , 19 <u>72</u> to <u>Sep 6</u> , 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Sep 6</u> , 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                   |  |                                                                                                                                                                                                             |  |                                                                                                              |
| 23A. SIGNATURE <u>William R. Davidson Jr. M.D.</u> DEGREE <u>M.D.</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                             |  | 23B. DATE SIGNED <u>Sep 6, 1972</u>                                                                          |
| 23C. PHYSICIAN'S NAME (Type) <u>William R. Davidson Jr. M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23D. ADDRESS <u>Maryland General Hospital</u>                                                                                                                                                               |  |                                                                                                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE <u>9/11/72</u>                                                                                                                                                                                    |  | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cem.</u>                                            |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24E. STATE <u>Md.</u>                                                                                                                                                                                       |  |                                                                                                              |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR <u>Sidney Johnson</u>                                                                                                                                                                |  | 25C. FUNERAL DIRECTOR <u>Edw. S. MacNabb Sons, Inc.</u> ADDRESS <u>301 Frederick Avenue Catonsville, Md.</u> |

Box 3  
Harmon, W. 21073  
210-2305  
Night 14 1/2 miles

301 Frederick Avenue  
Cincinnati, Ohio  
210-2305  
Night 14 1/2 miles

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | 72 08632                                                                                                                               |                                           | Z-162                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | REG. NO.                                                                                                                               |                                           | STATE OF MARYLAND-DEMN                                                                        |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Pelagia Lillian Zubrowski</u>                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><u>9/9/72</u> <u>1755</u> A.M.                                                                            |                                           |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>201</u> |                                           |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>413 S. Wolfe St. Baltimore, Md 31</u>                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                    |                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  | E. STREET AND NUMBER<br><u>413 S. Wolfe St</u>                                                                                         |                                           |                                                                                               |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                               | 6. RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>12/12/89</u>                                                                                                    | 9. AGE (In years last birthday) <u>82</u> | If Under 1 Tr. Months: Days: Hours: Min.                                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  | 11. BIRTHPLACE (State or foreign country)<br><u>Poland</u>                                                                             |                                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>                                                  |  |
| 13. FATHER'S NAME<br><u>Casimir Cieslewicz</u>                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><u>Agnes Sobus</u>                                                                                         |                                           |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>218-18-2698-D</u>                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br><u>218-18-2698-D</u>                                                                                        |                                           | 17. INFORMANT<br><u>Margie Borowicz 413 S. Wolfe St</u>                                       |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |                                                                                                                                                             |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>CARCINOMA OVARY</u><br><u>Local + distant metastases</u>                  |                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>30 months</u>                              |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                |                     |                                                                                                                                                             |  |                                                                                                                                        |                                           |                                                                                               |  |
| 19A. DATE OF OPERATION<br><u>9/5/72</u>                                                                                                                                                                                                                                                                                                               |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                              |                                           | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                     |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                            |                                           |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                           |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                             |                                           |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/5/72</u> to <u>9/9/72</u> that (I) (we) last saw the deceased alive on <u>9/5/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                  |                     |                                                                                                                                                             |  |                                                                                                                                        |                                           |                                                                                               |  |
| 23A. SIGNATURE<br><u>Irvin B. Kaplan M.D.</u>                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>        |                                           | 23B. DATE SIGNED<br><u>9/11/72</u>                                                            |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Irvin B. Kaplan M.D.</u>                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |  | 23D. ADDRESS<br><u>129 S. Broadway BALTO. MD.</u>                                                                                      |                                           |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                             |                     | 24B. DATE<br><u>9/13/72</u>                                                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>St. Stanislaus Cemetery</u>                                                                   |                                           | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md</u>                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                                 |                     | 25B. NAME OF REGISTRAR<br><u>Irvin B. Kaplan</u>                                                                                                            |  | 25C. FUNERAL DIRECTOR<br><u>M. F. Sadowski &amp; Sons</u>                                                                              |                                           | ADDRESS<br><u>1808 Eastern Ave</u>                                                            |  |



| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                        |                                  | 2. DATE OF DEATH                                                                                        |  | 3. DATE PRONOUNCED DEAD                                                  |  | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD              |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| WILBER J. GREGG                                                                                                                                                                                                                                                                                                                                                                                               |                                  | Known <input type="checkbox"/> Estimated <input type="checkbox"/>                                       |  | Month Day Year                                                           |  | Month Day Year                                                      |  | September 5, 1972 3:30 P. M.                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                                                                                                          |                                  | ADDRESS OR LOCATION                                                                                     |  | STATE                                                                    |  | B. COUNTY                                                           |  | Maryland                                                                                   |  |
| 3411 Virginia Avenue                                                                                                                                                                                                                                                                                                                                                                                          |                                  | 10-16-72                                                                                                |  |                                                                          |  |                                                                     |  | 2716                                                                                       |  |
| 6. SEX                                                                                                                                                                                                                                                                                                                                                                                                        | 7. RACE                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>        |  | C. CITY OR TOWN                                                          |  | D. INSIDE CITY LIMITS?                                              |  |                                                                                            |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                          | Negro                            | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                      |  | Baltimore                                                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                            |  |
| 9. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                              | 10. AGE (In years last birthday) | 11. BIRTHPLACE (State or foreign country)                                                               |  | 12. CITIZEN OF WHAT COUNTRY?                                             |  | 13. FATHER'S NAME                                                   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |
| FEB. 4, 1947                                                                                                                                                                                                                                                                                                                                                                                                  | 25                               | BALTIMORE, MARYLAND                                                                                     |  | USA                                                                      |  | WILBUR JOHN GREGG, SR.                                              |  | UNEMPLOYED                                                                                 |  |
| 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                      |                                  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |  | 17. SOCIAL SECURITY NO.                                                  |  | 18. INFORMANT                                                       |  | ADDRESS                                                                                    |  |
| ROSETTA BROWN                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | YES VIETNAM WAR                                                                                         |  |                                                                          |  | ROSETTA GREGG                                                       |  | 3411 VIRGINIA AVE.                                                                         |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                            |                                  | CAUSE OF DEATH                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |                                                                     |  |                                                                                            |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                    |                                  | Gunshot wound of chest                                                                                  |  |                                                                          |  |                                                                     |  |                                                                                            |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                             |                                  | (A) IMMEDIATE CAUSE                                                                                     |  |                                                                          |  |                                                                     |  |                                                                                            |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                     |                                  | DUE TO, OR AS A CONSEQUENCE OF:                                                                         |  |                                                                          |  |                                                                     |  |                                                                                            |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |                                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                     |  |                                                                          |  |                                                                     |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |                                  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                     |  |                                                                          |  |                                                                     |  |                                                                                            |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |                                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  | 21. AUTOPSY? (Yes or No)                                                 |  |                                                                     |  |                                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |                                  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |                                                                     |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |                                  | Basement                                                                                                |  | 3411 Virginia Avenue                                                     |  |                                                                     |  |                                                                                            |  |
| 22D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                 |                                  | 22E. INJURY OCCURRED                                                                                    |  | 22F. HOW DID INJURY OCCUR?                                               |  |                                                                     |  |                                                                                            |  |
| 9-5-72                                                                                                                                                                                                                                                                                                                                                                                                        |                                  | Unk. m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>    |  | Self-inflicted                                                           |  |                                                                     |  |                                                                                            |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  | CHIEF MEDICAL EXAMINER                                                                                  |  | DATE SIGNED                                                              |  |                                                                     |  |                                                                                            |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                              |                                  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                          |  |                                                                          |  |                                                                     |  |                                                                                            |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |                                  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                     |  |                                                                          |  |                                                                     |  |                                                                                            |  |
| William P. Mulloy, M.D.                                                                                                                                                                                                                                                                                                                                                                                       |                                  |                                                                                                         |  |                                                                          |  |                                                                     |  |                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                      |                                  | 24B. DATE                                                                                               |  | 24C. NAME OF CEMETERY or CREMATORY                                       |  | 24D. LOCATION (City, town, or county) (State)                       |  |                                                                                            |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                        |                                  | 9/9/72                                                                                                  |  | CEDAR HILL CEMETERY                                                      |  | BALTIMORE MD.                                                       |  |                                                                                            |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                               |                                  | 25B. NAME OF REGISTRAR                                                                                  |  | 25C. FUNERAL DIRECTOR                                                    |  | ADDRESS                                                             |  |                                                                                            |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                                                   |                                  | Sidney H. Whorton                                                                                       |  | LEWIS T GWYNN                                                            |  | 4517 PARK HEIGHTS AVE.                                              |  |                                                                                            |  |

10-16-1972 - Letter from the Clerk's Office, Court of Common Pleas, Baltimore, Md.  
stating that the marriage records of Baltimore City have been checked  
and there is no record of a license having been issued.

September 25, 1972 (Dated) and signed by

Paul L. Chester, Clerk

HRS (SN)



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                |  |                                                                                          |  |                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| K-520                                                                                                                                                                                                                                                                                           |  | 72 08634                                                                                                                                                                                       |  | BALTIMORE CITY HEALTH DEPARTMENT                                                         |  | REG. NO. 72 08634                                                                                                                                           |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                |  | STATE OF MARYLAND-DEME                                                                   |  |                                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) PAUL B. KOOMS JR                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                |  | 2. DATE AND HOUR OF DEATH<br>9/9/72 4:05 P.M.                                            |  |                                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>LUTHERAN HOSPITAL OF<br>46 MD. 730, ASHBURTON ST.<br>BALTO. MD. 21216                                                                                                                                                                                   |  |                                                                                                                                                                                                |  | A. STATE<br>Md                                                                           |  |                                                                                                                                                             |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                            |  |                                                                                                                                                                                                |  | C. CITY OR TOWN<br>BALTO.                                                                |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  |
| 5. SEX<br>M                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                |  | 6. RACE<br>W                                                                             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                     |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                              |  | 8. DATE OF BIRTH<br>4-22-24                                                              |  | 9. AGE (In years last birthday)<br>48                                                                                                                       |  |
| 11. BIRTHPLACE (State or foreign country)<br>Md                                                                                                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY                                                                                                                                                                    |  | 13. FATHER'S NAME<br>PAUL B. KOOMS SR                                                    |  | 14. MOTHER'S MAIDEN NAME<br>IRIS Stevenson                                                                                                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No                                                                                                                                                                                                                            |  | 16. SOCIAL SECURITY NO.<br>216-16-7246                                                                                                                                                         |  | 17. INFORMANT<br>IRIS KOOMS                                                              |  | ADDRESS<br>1102 WALNUT AVE                                                                                                                                  |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                              |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Acute Cardiorespiratory Arrest |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 min.                                                                                                     |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                  |  | (B) Acute Hepatorenal failure<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                               |  | (C)                                                                                      |  |                                                                                                                                                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Hepatomegaly                                                                                                                                          |  |                                                                                                                                                                                                |  |                                                                                          |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                     |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                               |  | 20A. AUTOPSY? (Yes or No)<br>YES                                                         |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES                                                                                 |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                        |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)              |  |                                                                                                                                                             |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                      |  | 21F. HOW DID INJURY OCCUR?                                                               |  |                                                                                                                                                             |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/1/72 to 9/9/72 that (I) (we) last saw the deceased alive on 9/9/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                                                                |  |                                                                                          |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br>S. S. Dongre                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                |  | 23B. DATE SIGNED<br>9/9/72                                                               |  | 23C. PHYSICIAN'S NAME (Type)<br>DR. S. S. DONGRE                                                                                                            |  |
| 23D. ADDRESS<br>730, ASHBURTON ST. BALTO. MD. 21216                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                |  | 23E. DEGREE<br>DEGREE                                                                    |  | 23F. DEGREE<br>DEGREE                                                                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>CREMATION                                                                                                                                                                                                                                           |  | 24B. DATE<br>9/11/72                                                                                                                                                                           |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Houdon Park                                        |  | 24D. LOCATION<br>BALTO MD                                                                                                                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                  |  | 25B. NAME OF REGISTRAR<br>Lillian Whitson                                                                                                                                                      |  | 25C. FUNERAL DIRECTOR<br>Walter J. De... 1630 Edmondson Ave                              |  | ADDRESS                                                                                                                                                     |  |

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Y-300 72 08635                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                               | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                    |                                                                       | REG. NO. 72 08635                                                                             |                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                               | CERTIFICATE OF DEATH                                                                                                                                                                                                |                                                                       | STATE OF MARYLAND-DEMH                                                                        |                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Votta, Anthony D.</b>                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                               | 2. DATE AND HOUR OF DEATH<br><b>9-8-72</b>                                                                                                                                                                          |                                                                       | <b>2:35pm</b> M.                                                                              |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                                                               |                                                                       |                                                                                               |                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>37 Mercy, Hospital</b>                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                               | A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>                                                                                                                                                                     |                                                                       |                                                                                               |                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                               | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                 |                                                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                               |
|                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                               | E. STREET AND NUMBER<br><b>905 St. Agnes Lane</b>                                                                                                                                                                   |                                                                       |                                                                                               |                                               |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                               | 6. RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 5, 1900</b>       |                                                                                                                                                                                                                     | 9. AGE (In years last birthday)<br><b>72</b>                          | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |                                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY             |                                                                                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>          |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Frank Votta</b>                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                               | 14. MOTHER'S MAIDEN NAME<br><b>Susanna Cuneo</b>                                                                                                                                                                    |                                                                       |                                                                                               |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>213-05-7960</b> |                                                                                                                                                                                                                     | 17. INFORMANT<br><b>Mrs. Anthony D. Votta 905 St. Agnes La. 21207</b> |                                                                                               |                                               |
| 18. <b>185 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |                                                                                                                                                             |                                               | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Coronary Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Coronary Artery Disease</b> |                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                               |
| II                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                               | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Anemia; Renal Failure</b>                                                    |                                                                       |                                                                                               |                                               |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                               | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                           |                                                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                               |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                               | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                         |                                                                       |                                                                                               |                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                           |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                               | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                          |                                                                       |                                                                                               |                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug 30</b> 19 <b>72</b> to <b>Sept 8</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Sept 8</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.       |                         |                                                                                                                                                             |                                               |                                                                                                                                                                                                                     |                                                                       |                                                                                               |                                               |
| 23A. SIGNATURE<br><b>T.P. Detrick</b>                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                               | 23B. DATE SIGNED<br><b>1972</b>                                                                                                                                                                                     |                                                                       |                                                                                               |                                               |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                               | 23D. ADDRESS<br><b>Witke Inc; 1630 Edmondson Ave. 21228</b>                                                                                                                                                         |                                                                       |                                                                                               |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                           |                         | 24B. DATE<br><b>9/12/72</b>                                                                                                                                 |                                               | 24C. NAME of CEMETERY or CREMATORY<br><b>Lorraine Park Cemetery</b>                                                                                                                                                 |                                                                       | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Maryland</b>                       |                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><b>Anthony D. Votta</b>                                                                                                           |                                               | 25C. FUNERAL DIRECTOR<br><b>Witke Inc</b>                                                                                                                                                                           |                                                                       | ADDRESS<br><b>1630 Edmondson Ave. 21228</b>                                                   |                                               |

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             |                              | REG. NO. 72 08636                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------|
| 72 08636                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             |                              | STATE OF MARYLAND - DASH                                                                      |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                   |                      | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                              |                                                                                               |
| HAMSON, ELLA                                                                                                                                                                                                                                                                                                             |                      | SEPTEMBER 7, 1972   3:50 P.M.                                                                                                                               |                              |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                   |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                       |                              |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>ST AGNES HOSPITAL                                                                                                                                                                                                                                                                |                      | A. STATE<br>MARYLAND                                                                                                                                        |                              |                                                                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                     |                      | C. CITY OR TOWN<br>BALTIMORE                                                                                                                                |                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 40                                                                                                                                                                                                                                                                                                                       |                      | E. STREET AND NUMBER<br>230 SOUTH GILMOR STREET                                                                                                             |                              | 21223                                                                                         |
| 5. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                         | 6. RACE<br>CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>09 14 79 | 9. AGE (In years last birthday)<br>92                                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE                                                                                                                                                                                                                 |                      | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND                                                                                                       |                              | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                        |
| 13. FATHER'S NAME<br>JAMES PURDY                                                                                                                                                                                                                                                                                         |                      | 14. MOTHER'S MAIDEN NAME<br>ELIZABETH (CHANEY)                                                                                                              |                              |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                           |                      | 16. SOCIAL SECURITY NO.<br>216 46 8074                                                                                                                      |                              |                                                                                               |
| 17. INFORMANT<br>AVE BALTIMORE MARYLAND 21229                                                                                                                                                                                                                                                                            |                      | ADDRESS<br>ST AGNES HOSPITAL CATON & WILKENS                                                                                                                |                              |                                                                                               |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ACUTE ANTERIOR SEPTAL MI                                                                         |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                              |                                                                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                           |                      | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>CORONARY ARTERIOSCLEROSIS                                                                         |                              |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                   |                      | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                              |                                                                                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                              | 20A. AUTOPSY? (Yes or No)<br>NO                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                    |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                              | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                              | 21F. HOW DID INJURY OCCUR?                                                                    |
| 22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 7 1972 to SEPTEMBER 7 1972, that (X) (we) last saw the deceased alive on SEPTEMBER 7 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. |                      |                                                                                                                                                             |                              |                                                                                               |
| 23A. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             |                              | 23B. DATE SIGNED<br>9/7/72                                                                    |
| 23C. PHYSICIAN'S NAME (Type)<br>AGATON H. ESCOBARTE, M.D.                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             |                              | 23D. ADDRESS<br>CATON & WILKENS AVE BALTIMORE MARYLAND                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                       |                      | 24B. DATE<br>9/11/72                                                                                                                                        |                              | 24C. NAME OF CEMETERY or CREMATORY<br>Loudon Park Cemetery                                    |
| 24D. LOCATION<br>Baltimore Maryland                                                                                                                                                                                                                                                                                      |                      | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                              |                              |                                                                                               |
| 25B. NAME OF REGISTRAR<br><i>[Signature]</i>                                                                                                                                                                                                                                                                             |                      | 25C. FUNERAL DIRECTOR<br>Witzke Inc. 1630 Edmondson Ave. 21228                                                                                              |                              |                                                                                               |

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SEPTEMBER 7, 1952

WASH DC  
BALTIMORE  
AND NORTH CAROLINA

ST. AGNES HOSPITAL

SEPTEMBER 7, 1952

U.S.A. MORRIS

DEED ELIZABETH (CONVEY)

THE ST. AGNES HOSPITAL  
BALTIMORE, MARYLAND

NO

SEPTEMBER 7, 1952  
SEPTEMBER 7, 1952  
XX

CATON & WILSON AND BALTIMORE  
ST. AGNES HOSPITAL RECORDS

U.S.A. MORRIS

U.S.A. MORRIS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>W-235</span> <span>72 08637</span> <span>BALTIMORE CITY HEALTH DEPT.</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REG. NO. 72 08637</span> <span>STATE OF MARYLAND-DEM</span> </div>                   |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                      |
| BIRTH NO. _____<br>1. NAME OF DECEASED (Type or Print) <u>MAY W. WESTON</u>                                                                                                                                                                                                                                                                                             |                                                                                                                                                                        | 2. DATE AND HOUR OF DEATH<br><u>9/7/72</u> <u>4:45</u> A. M.                                                                                                                                                                                                                                                    |                                                                                      |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Union Memorial Hospital</u>                                                                                                                                                               |                                                                                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY _____<br>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>4323 Marble Hall Rd.</u> |                                                                                      |
| 5. SEX <u>Female</u><br>6. RACE <u>White</u>                                                                                                                                                                                                                                                                                                                            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>05-05-1891</u><br>9. AGE (In years last birthday) <u>80</u> 81                                                                                                                                                                                                                              | If Under 1 Yr. Months: _____ Days: _____<br>If Under 24 Hrs. Hours: _____ Min. _____ |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____<br>10B. KIND OF BUSINESS OR INDUSTRY _____                                                                                                                                                                                                                            |                                                                                                                                                                        | 11. BIRTHPLACE (State or foreign country) <u>Md.</u><br>12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                                                                                                                                                 |                                                                                      |
| 13. FATHER'S NAME <u>George W. Wonderly</u>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                        | 14. MOTHER'S MAIDEN NAME <u>Laura E.</u>                                                                                                                                                                                                                                                                        |                                                                                      |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                                   |                                                                                                                                                                        | 16. SOCIAL SECURITY NO. <u>216-01-7620</u><br>17. INFORMANT ADDRESS <u>T.B. Weston 600 Title Bldg. Balto. 21202</u>                                                                                                                                                                                             |                                                                                      |
| 18. CAUSE OF DEATH<br><u>560.91</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                      |
| (A) IMMEDIATE CAUSE <u>M.I.</u><br>DUE TO, OR AS A CONSEQUENCE OF: _____<br>(B) <u>INTESTINAL OBSTRUCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF: _____<br>(C) _____                                                                                                                                                                                                     |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                      |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____                                                                                                                                                                                                                            |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                      |
| 19A. DATE OF OPERATION _____<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____                                                                                                                                                                                                                                                                                  |                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No) _____<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____                                                                                                                                                                                                   |                                                                                      |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) _____                                                                                                                                                                                                                           |                                                                                                                                                                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____                                                                                                                                |                                                                                      |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____<br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                               |                                                                                                                                                                        | 21F. HOW DID INJURY OCCUR? _____                                                                                                                                                                                                                                                                                |                                                                                      |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/6/72</u> 19 to <u>9/7</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>9/7/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                  |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                      |
| 23A. SIGNATURE <u>John Taylor</u><br>23C. PHYSICIAN'S NAME (Type) <u>John Taylor</u>                                                                                                                                                                                                                                                                                    |                                                                                                                                                                        | 23B. DATE SIGNED <u>9/7/72</u><br>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                                                                               |                                                                                      |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                        | 24B. DATE <u>9/9/72</u><br>24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u><br>24D. LOCATION (City, town, or county) (State) <u>Baltimore City</u>                                                                                                                                                |                                                                                      |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                        | 25B. NAME OF REGISTRAR <u>Adrian [unclear]</u><br>25C. FUNERAL DIRECTOR ADDRESS <u>Witzke Inc. 1630 Edmondson Ave. Balto.</u>                                                                                                                                                                                   |                                                                                      |







## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08638

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Leon (Buck) Finney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 9 7 72<br>8:25 A.M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1836 E. Eager Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>9 7 72<br>8:25 A.M.                                                                       |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7. RACE<br><b>Negro</b>                                                                                                                |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                    |  |
| 9. DATE OF BIRTH<br><b>9-26-25</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10. AGE (in years lost birthday)<br><b>46</b>                                                                                          |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                           |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>                                                                               |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 17. SOCIAL SECURITY NO.                                                                                                                |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Emma</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 18. INFORMANT<br><b>Myra Holton 2023 Braddish Ave.</b>                                                                                 |  |
| 19. CAUSE OF DEATH<br><b>571.8</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Fatty liver</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                           |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |
| 21. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                               |  |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |  |
| 22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                 |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b> M.D.<br>EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b><br>DATE SIGNED <b>9-7-72</b> |  |                                                                                                                                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24B. DATE<br><b>9-11-72</b>                                                                                                            |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Cedar Hill Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24D. LOCATION (City, town, or county) (State)<br><b>Anne Arundel Cty., Md.</b>                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 25B. NAME OF REGISTRAR<br><b>Adrian J. Houston</b>                                                                                     |  |
| 25C. FUNERAL DIRECTOR<br><b>Wm C March</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS<br><b>928 E North Ave.</b>                                                                                                     |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  |                                                                                          |                            |                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                     |         | 72 08639                                                                      |                  | 72 08639                                                                                 |                            | REG. NO.                                                                 |  |
| BIRTH NO. 8536                                                                                                                                                                                                                                                                                                                       |         | 72 08639                                                                      |                  | CERTIFICATE OF DEATH                                                                     |                            | STATE OF MARYLAND-DEPT                                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                               |         |                                                                               |                  | 2. DATE AND HOUR OF DEATH                                                                |                            |                                                                          |  |
| SAUNDERS, Ralieggh Denver                                                                                                                                                                                                                                                                                                            |         |                                                                               |                  | September 8, 1972                                                                        |                            | 11:05 A.M.                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                               |         |                                                                               |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)    |                            |                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Veterans Administration Hospital<br>3900 Loch Raven Blvd.<br>Baltimore, Maryland 21218                                                                                                                                  |         |                                                                               |                  | A. STATE                                                                                 |                            | B. COUNTY                                                                |  |
|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  | Virginia                                                                                 |                            | Richmond                                                                 |  |
| C. CITY OR TOWN                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  | D. INSIDE CITY LIMITS?                                                                   |                            |                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |                            |                                                                          |  |
| E. STREET AND NUMBER                                                                                                                                                                                                                                                                                                                 |         |                                                                               |                  | 600 Hancock Street                                                                       |                            |                                                                          |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                               | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                                          | If Under 1 Yr. Months Days |                                                                          |  |
| Male                                                                                                                                                                                                                                                                                                                                 | Negro   | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 6-28-30          | 42                                                                                       |                            |                                                                          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                          |         | 10B. KIND OF BUSINESS OR INDUSTRY                                             |                  | 11. BIRTHPLACE (State or foreign country)                                                |                            | 12. CITIZEN OF WHAT COUNTRY?                                             |  |
| Maintenance                                                                                                                                                                                                                                                                                                                          |         |                                                                               |                  | Virginia                                                                                 |                            | U.S.A.                                                                   |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                    |         |                                                                               |                  | 14. MOTHER'S MAIDEN NAME                                                                 |                            |                                                                          |  |
| Charlie Saunders                                                                                                                                                                                                                                                                                                                     |         |                                                                               |                  | Fanny Jackson                                                                            |                            |                                                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                             |         |                                                                               |                  | 16. SOCIAL SECURITY NO.                                                                  |                            | 17. INFORMANT                                                            |  |
| Yes 2 - -51 to 2 - -54                                                                                                                                                                                                                                                                                                               |         |                                                                               |                  | 231-48-7675                                                                              |                            | Records                                                                  |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |         |                                                                               |                  | ADDRESS                                                                                  |                            |                                                                          |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |         |                                                                               |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                            |                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  | Larngaeal Carcinoma with Metastases                                                      |                            |                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |                            |                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  |                                                                                          |                            |                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                      |                            |                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  |                                                                                          |                            |                                                                          |  |
| 19. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                |         |                                                                               |                  | 20A. AUTOPSY? (Yes or No)                                                                |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                |         |                                                                               |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                        |         |                                                                               |                  | 21E. INJURY OCCURRED                                                                     |                            | 21F. HOW DID INJURY OCCUR?                                               |  |
|                                                                                                                                                                                                                                                                                                                                      |         |                                                                               |                  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                            |                                                                          |  |
| 22. I certify that (1) (this hospital) attended the deceased from August 30, 1972 to September 8, 1972, that (2) (we) lost saw the deceased alive on September 8, 1972 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.       |         |                                                                               |                  |                                                                                          |                            |                                                                          |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                       |         |                                                                               |                  | 23B. DATE SIGNED                                                                         |                            |                                                                          |  |
| Marguerite T. Moran M.D.                                                                                                                                                                                                                                                                                                             |         |                                                                               |                  | 9/9/72                                                                                   |                            |                                                                          |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                         |         |                                                                               |                  | 23D. ADDRESS                                                                             |                            |                                                                          |  |
| Marguerite T. Moran M.D.                                                                                                                                                                                                                                                                                                             |         |                                                                               |                  | 3900 Loch Raven Blvd., Balto., Md. 21218                                                 |                            |                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                             |         | 24B. DATE                                                                     |                  | 24C. NAME of CEMETERY or CREMATORY                                                       |                            | 24D. LOCATION (City, town, or county) (State)                            |  |
| Burial                                                                                                                                                                                                                                                                                                                               |         | 9-13-72                                                                       |                  | Gettysburg Nat. Cem.                                                                     |                            | Gettysburg, Pa.                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                      |         | 25B. NAME OF REGISTRAR                                                        |                  | 25C. FUNERAL DIRECTOR                                                                    |                            | ADDRESS                                                                  |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                          |         | Sidney W. W. W.                                                               |                  | Wm C March                                                                               |                            | 928 E North Ave.                                                         |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                |                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| K-155<br>72 08640<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | BALTIMORE CITY HEALTH DEPARTMENT<br>72 08640<br>REG. NO.                                                                                                                                                                                                                                                                                       |                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>KAUFMAN, DAVID HOOD</b>                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 2. DATE AND HOUR OF DEATH<br><b>SEPTEMBER 5 1972   7:30A M.</b>                                                                                                                                                                                                                                                                                |                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST. AGNES HOSPITAL</b><br><b>40 CATON &amp; WILKENS AVENUE</b><br><b>BALTIMORE MARYLAND 21229</b>                                                                                                                                                                                               |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b><br>C. CITY OR TOWN <b>Catonsville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>113 SOUTH SYMINGTON AVE NUE 21228</b> |                                                                             |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><b>CAUCASIAN</b>                                                                            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                    | 8. DATE OF BIRTH<br><b>06 14 10</b>                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TECHNICIAN</b>                                                                                                                                                                                                                                                                                         |                                                                                                        | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PURCHASING</b>                                                                                                                                                                                                                                                                                         | 9. AGE (In years lost birthday)<br><b>62</b>                                |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                  |                                                                             |
| 13. FATHER'S NAME<br><b>DAVID KAUFMAN</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 14. MOTHER'S MAIDEN NAME<br><b>ALICE VERNAY</b>                                                                                                                                                                                                                                                                                                |                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                    |                                                                                                        | 16. SOCIAL SECURITY NO.<br><b>216 05 2874</b>                                                                                                                                                                                                                                                                                                  |                                                                             |
| 17. INFORMANT<br><b>&amp; WILKENS AVENUE 21229</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | ADDRESS<br><b>ST. AGNES HOSPITAL RECORDS CATON</b>                                                                                                                                                                                                                                                                                             |                                                                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Acute pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Left ventricular failure</b><br><b>Left coronary artery occlusion</b>                                                          |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b>                                                                                                                                                                                                                                                                                   |                                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                |                                                                             |
| 19A. DATE OF OPERATION<br><b>21</b>                                                                                                                                                                                                                                                                                                                                                                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                                                                                                                                                                                                                        | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                       |                                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                     |                                                                             |
| 22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>SEPTEMBER 5 1972</b> to <b>SEPTEMBER 5 19 72</b> , that <del>X</del> (we) lost saw the deceased alive on <b>SEPTEMBER 5 19 72</b> and that <del>in</del> <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <del>X</del> (We) (did) <del>XXXX</del> view the body after death. |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                |                                                                             |
| 23A. SIGNATURE<br><b>Vincent H. Wang M.D.</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                | 23B. DATE SIGNED<br><b>09 05 72</b>                                         |
| 23C. PHYSICIAN'S NAME (Type)<br><b>VINCENT H. WANG M.D.</b>                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                | 23D. ADDRESS<br><b>Caton &amp; Wilkens Ave 21229.</b>                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                | 24B. DATE<br><b>9/7/1972</b>                                                                           | 24C. NAME of CEMETERY or CREMATORY<br><b>Loudon Park</b>                                                                                                                                                                                                                                                                                       | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 25B. NAME OF REGISTRAR<br><b>Shirley H. Hester</b>                                                                                                                                                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>                            |
|                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | ADDRESS<br><b>5151 Balto. Nat'l. Pike</b>                                                                                                                                                                                                                                                                                                      |                                                                             |

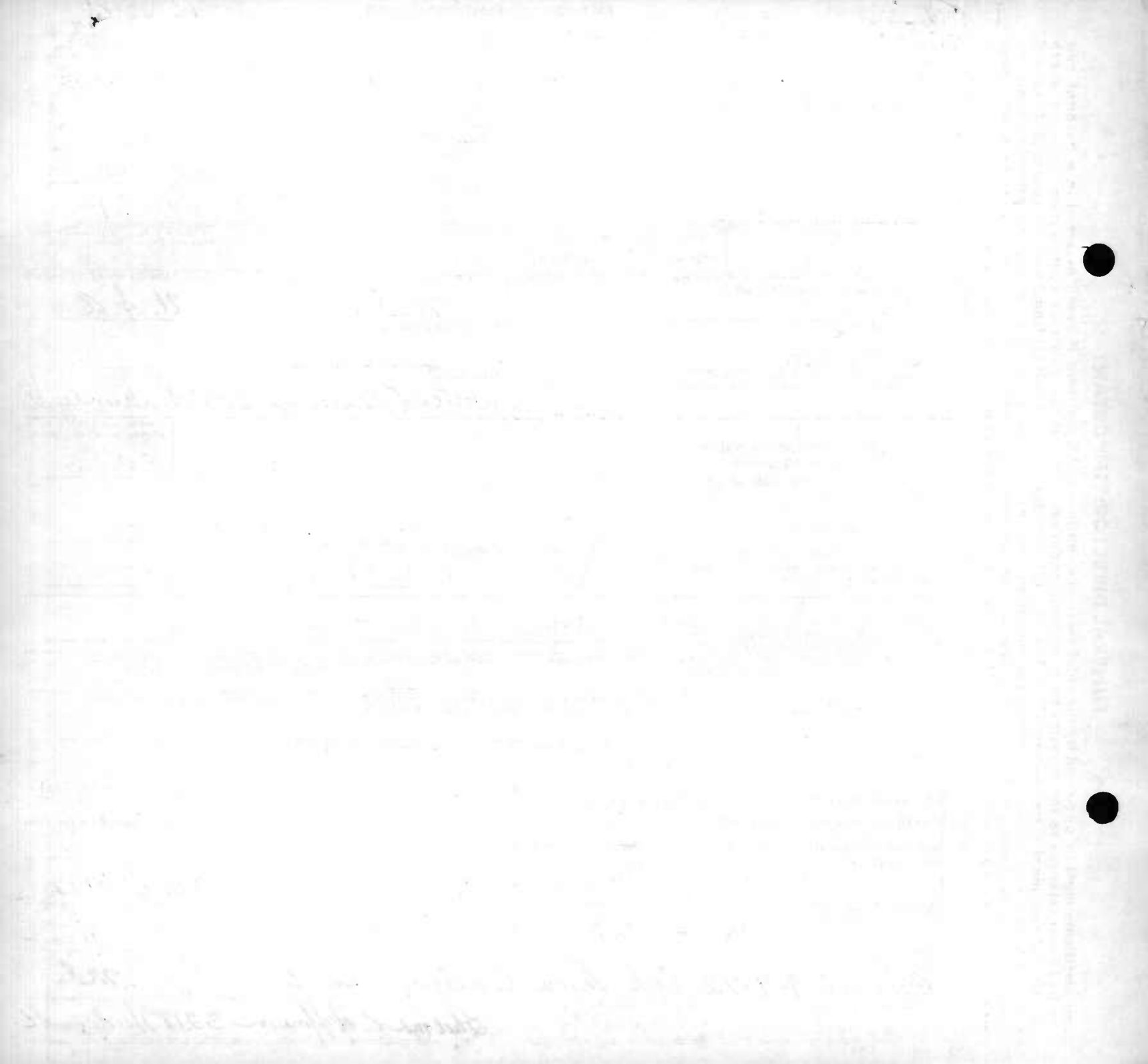
55 20 00



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                         |  | REG. NO. 72 08641                                                                                                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| K-530 72 08641                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                         |  | CERTIFICATE OF DEATH                                                                                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                                                                                                               |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                             |  |
| KENNEDY MINERVA L                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | Sept 6, 1972, 8-15 am M.                                                                                                                                                                                                                                                                                                |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY<br>MD. 2609                                                            |  |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION<br>Johns Hopkins Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6. IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                                                   |  | 7. C. CITY OR TOWN D. INSIDE CITY LIMITS?<br>BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                         |  |
| 8. BALTIMORE, MD 21205                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 9. E. STREET AND NUMBER<br>615 S. GRUNDY ST.                                                                                                                                                                                                                                                                            |  | 10. SEX 11. RACE 12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>F W. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 13. DATE OF BIRTH<br>Sept. 25, 1900                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 14. AGE (In years last birthday)<br>71 yrs                                                                                                                                                                                                                                                                              |  | 15. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                                                      |  |
| 16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 17. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                        |  | 18. BIRTHPLACE (State or foreign country)<br>Md.                                                                                                                                   |  |
| 19. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20. FATHER'S NAME<br>JESSE POWELL                                                                                                                                                                                                                                                                                       |  | 21. MOTHER'S MAIDEN NAME<br>CLARA SAUNDERS                                                                                                                                         |  |
| 22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23. SOCIAL SECURITY NO.<br>213-20-0295                                                                                                                                                                                                                                                                                  |  | 24. INFORMANT<br>Walter L. Kennedy 615 S. Grundy St.                                                                                                                               |  |
| 25. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>RENAL FAILURE                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>BIL. CHRONIC PYELONEPHROSIS<br>RECTOVESICAL FISTULA                                                                                                                               |  | 27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 days<br>2 yrs.<br>2 yrs.                                                                                                     |  |
| 28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>II<br>Arteriosclerotic Heart Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29. CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                 |  |                                                                                                                                                                                    |  |
| 30. MEDICAL CERTIFICATION<br>19A. DATE OF OPERATION<br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br>21D. TIME OF INJURY (APPROX.)<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>20A. AUTOPSY? (Yes or No)<br>YES<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21F. HOW DID INJURY OCCUR? |  | 31. I certify that (I) (this hospital) attended the deceased from Sept. 5 - 1972 to Sept 6 - 1972<br>that (I) (we) last saw the deceased alive on Sept 6, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 32. SIGNATURE<br>K.K. Pandya M.D.<br>32B. DATE SIGNED<br>Sept. 6, 1972                                                                                                             |  |
| 33. PHYSICIAN'S NAME (Type)<br>K.K. PANDYA M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 34. ADDRESS<br>Johns Hopkins Hospital, BALTIMORE, MD 21205                                                                                                                                                                                                                                                              |  | 35. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                      |  |
| 36. NAME OF REGISTRAR<br>F. J. H. H. H.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 37. FUNERAL DIRECTOR<br>H. J. H. H. H.                                                                                                                                                                                                                                                                                  |  | 38. ADDRESS<br>3218 Hudson St.                                                                                                                                                     |  |
| 39. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 40. DATE<br>9-9-72                                                                                                                                                                                                                                                                                                      |  | 41. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                                                                                                                             |  |
| 42. LOCATION<br>Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 43. DATE<br>9-9-72                                                                                                                                                                                                                                                                                                      |  | 44. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                                                                                                                             |  |

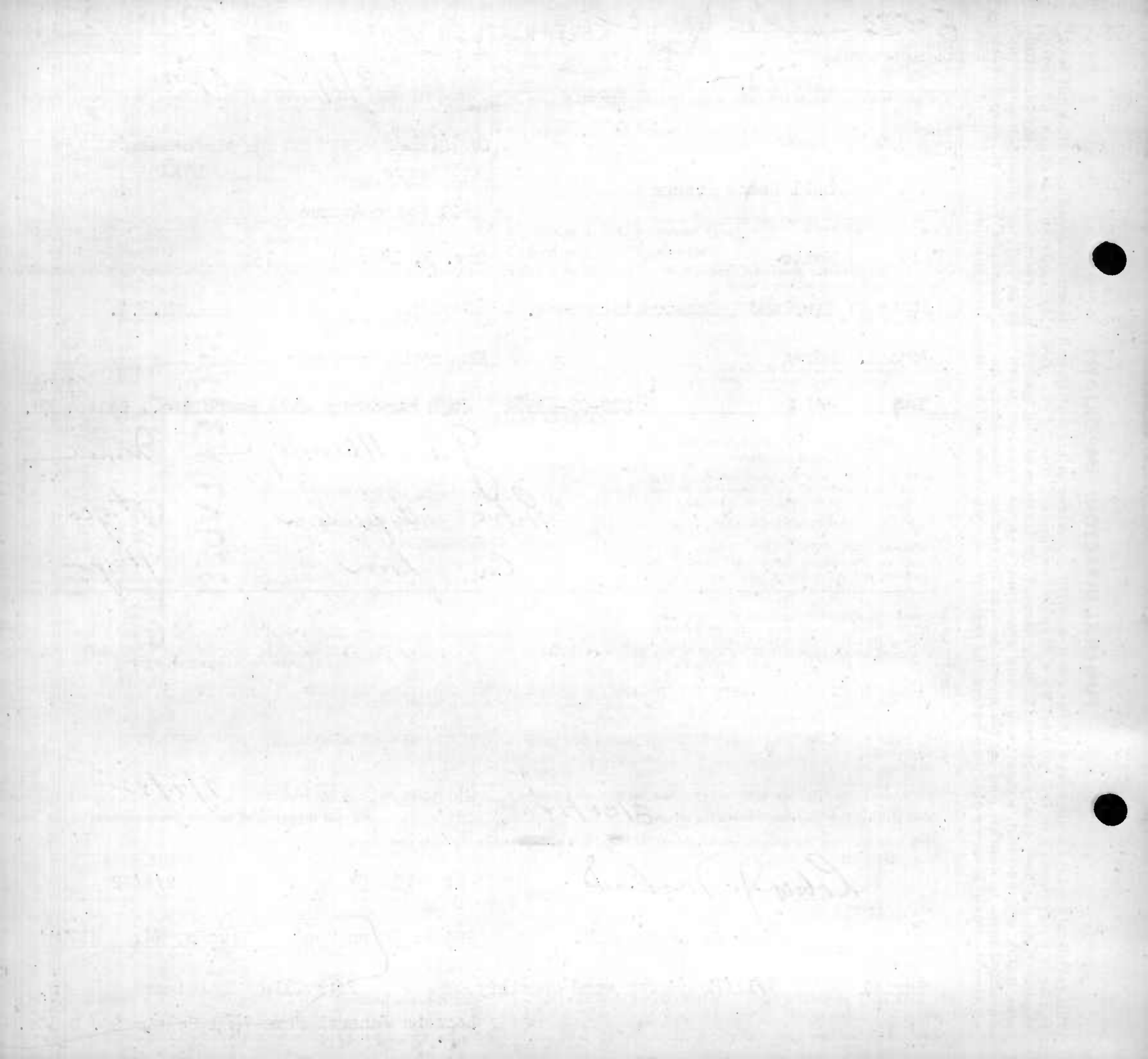




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

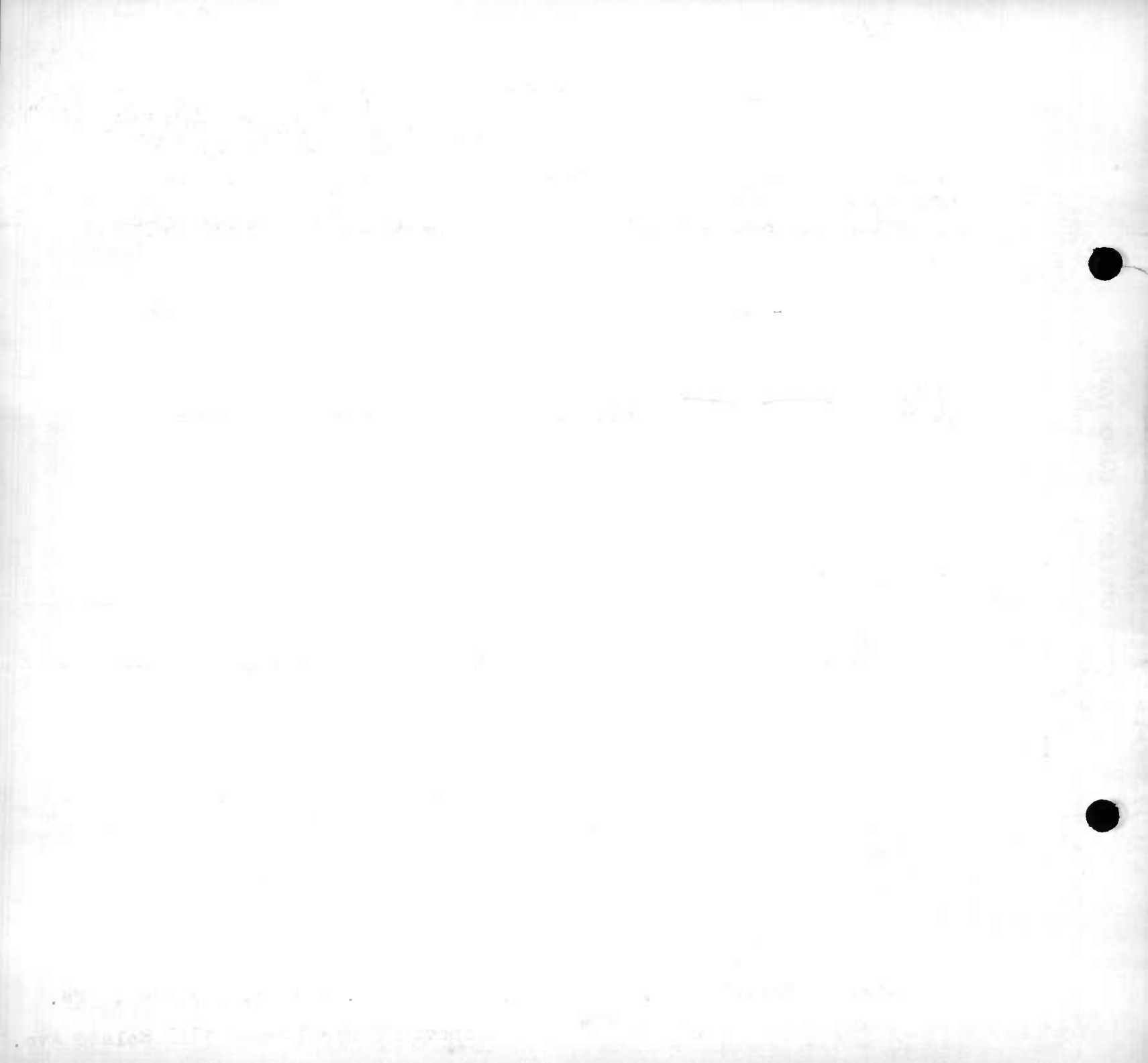
| E-536 72 08642                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                                                | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                             |                                                              | REG. NO. 72 08642                                                                                        |                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                | STATE OF MARYLAND - DEATH                                                                                                                                                    |                                                              |                                                                                                          |                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Harry J. Endres</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                | 2. DATE AND HOUR OF DEATH<br><u>9/7/72 8pm</u>                                                                                                                               |                                                              |                                                                                                          |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                        |                                                              |                                                                                                          |                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>00 4421 Raspe Avenue</u>                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                | A. STATE<br><u>Maryland</u>                                                                                                                                                  |                                                              | 8. COUNTY<br><u>2631</u>                                                                                 |                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                          |                                                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                | E. STREET AND NUMBER<br><u>4421 Raspe Avenue</u>                                                                                                                             |                                                              |                                                                                                          |                                               |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 6. RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 3, 1896</u>                        |                                                                                                                                                                              | 9. AGE (In years last birthday)<br><u>75</u>                 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                |                                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>State Of Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Construction Supt.</u> |                                                                                                                                                                              | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u> |                                                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
| 13. FATHER'S NAME<br><u>John H. Endres</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                | 14. MOTHER'S MAIDEN NAME<br><u>Margaret</u>                                                                                                                                  |                                                              |                                                                                                          |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)<br><u>Yes</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 16. SOCIAL SECURITY NO.<br><u>WW I 220-03-4358A</u>                                                                                                         |                                                                | 17. INFORMANT<br><u>John Wirebaugh</u>                                                                                                                                       |                                                              | ADDRESS<br><u>4421 Raspe Ave. Balto. Md. 21206</u>                                                       |                                               |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION<br><u>9/7/72</u> |                         |                                                                                                                                                             |                                                                | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>G.I. Hemorrhage</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Protr. Hypertension</u><br>(C) <u>Ca Liver</u> |                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>1 1/2 yrs</u><br><u>1 1/2 yrs</u> |                                               |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                |                                                                                                                                                                              |                                                              |                                                                                                          |                                               |
| 19A. DATE OF OPERATION<br><u>9/7/72</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                | 20A. AUTOPSY? (Yes or No)                                                                                                                                                    |                                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                     |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                  |                                                              |                                                                                                          |                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                | 21F. HOW DID INJURY OCCUR?                                                                                                                                                   |                                                              |                                                                                                          |                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 23</u> 19 <u>72</u> to <u>9/7/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/30/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                         |                         |                                                                                                                                                             |                                                                |                                                                                                                                                                              |                                                              |                                                                                                          |                                               |
| 23A. SIGNATURE<br><u>Robert J. Mahon</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                | 23B. DATE SIGNED<br><u>9/8/72</u>                                                                                                                                            |                                                              |                                                                                                          |                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>ROBERT J. MAHON, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                | 23D. ADDRESS<br><u>204 E. Joppa Road Towson, Md. 21204</u>                                                                                                                   |                                                              |                                                                                                          |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 24B. DATE<br><u>9/11/72</u>                                                                                                                                 |                                                                | 24C. NAME of CEMETERY or CREMATORY<br><u>Parkwood Cemetery</u>                                                                                                               |                                                              | 24D. LOCATION (City, town, or county) (State)<br><u>Parkville Baltimore Md.</u>                          |                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 25B. NAME OF REGISTRAR<br><u>David W. Wilson</u>                                                                                                            |                                                                | 25C. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home</u>                                                                                                                         |                                                              | ADDRESS<br><u>7401 Belair Rd. Balto. 21236</u>                                                           |                                               |



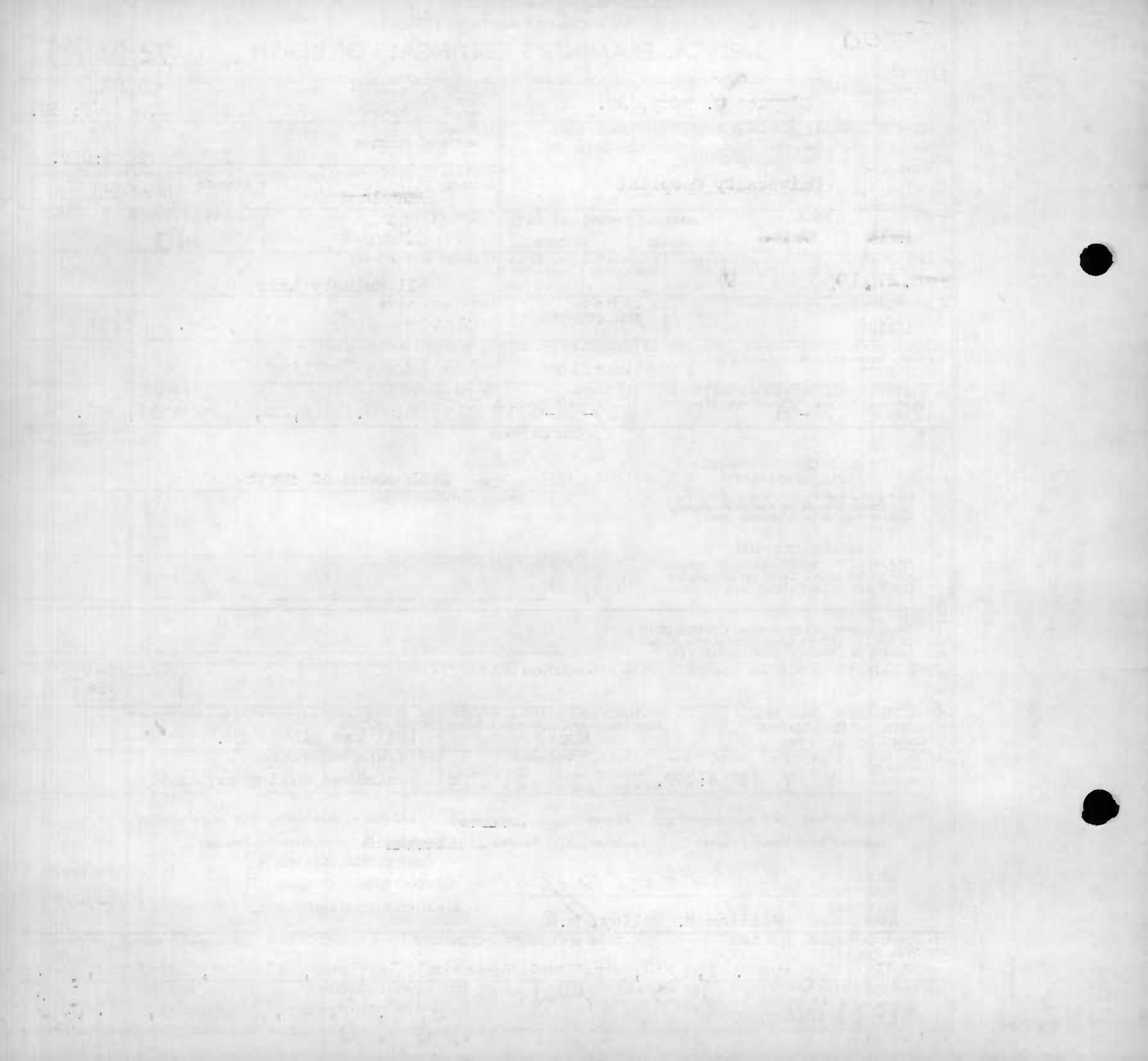
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                        |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| G-624                                                                                                                                                                                                                                                                                                  |  | 72 08643                                                                                |  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |  | REG. NO. 72 08643                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                              |  |                                                                                         |  | STATE OF MARYLAND - DEATH                                                             |  |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) GRUZIO, MRS. MARY A.                                                                                                                                                                                                                                            |  |                                                                                         |  | 2. DATE AND HOUR OF DEATH<br>9/7/72 5:40 P.M.                                         |  |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                 |  |                                                                                         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) |  |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                    |  | A. STATE                                                                              |  | B. COUNTY                                                            |  |
| Church Home Hospital                                                                                                                                                                                                                                                                                   |  | 100 N Broadway Baltimore, Md                                                            |  | 1747 Brookview Rd                                                                     |  | Baltimore                                                            |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                         |  | C. CITY OR TOWN                                                                       |  | D. INSIDE CITY LIMITS?                                               |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                         |  | Baltimore                                                                             |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX F                                                                                                                                                                                                                                                                                               |  |                                                                                         |  | 6. RACE W                                                                             |  |                                                                      |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                               |  |                                                                                         |  | 8. DATE OF BIRTH 5/15-98                                                              |  |                                                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                            |  |                                                                                         |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                     |  |                                                                      |  |
| homemaker - Housewife                                                                                                                                                                                                                                                                                  |  |                                                                                         |  | Poland                                                                                |  |                                                                      |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                      |  |                                                                                         |  | 14. MOTHER'S MAIDEN NAME                                                              |  |                                                                      |  |
| STANLEY GRYIOS                                                                                                                                                                                                                                                                                         |  |                                                                                         |  | AGNES ROMANEX                                                                         |  |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                               |  |                                                                                         |  | 16. SOCIAL SECURITY NO.                                                               |  | 17. INFORMANT                                                        |  |
| No                                                                                                                                                                                                                                                                                                     |  |                                                                                         |  | 16932 6367                                                                            |  | Daughter Josephine Stone                                             |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                     |  |                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |                                                                      |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                         |  |                                                                                         |  | (A) IMMEDIATE CAUSE                                                                   |  |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                            |  |                                                                                         |  | DUE TO, OR AS A CONSEQUENCE OF:                                                       |  |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                      |  |                                                                                         |  | ASHD, generalized arteriosclerosis                                                    |  |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                              |  |                                                                                         |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                         |  | (C) _____                                                                             |  |                                                                      |  |
| II                                                                                                                                                                                                                                                                                                     |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                       |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                        |  | 20A. AUTOPSY? (Yes or No)                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                        |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                          |  | 21E. INJURY OCCURRED                                                                    |  | 21F. HOW DID INJURY OCCUR?                                                            |  |                                                                      |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                            |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |  |                                                                                       |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8/27/1972 to 9/7/1972 that (I) (we) last saw the deceased alive on 9/7/1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                         |  |                                                                                         |  | 23B. DATE SIGNED                                                                      |  |                                                                      |  |
| Dr. Wong MD.                                                                                                                                                                                                                                                                                           |  |                                                                                         |  | 9/7/72                                                                                |  |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                           |  |                                                                                         |  | 23D. ADDRESS                                                                          |  |                                                                      |  |
| Dr. Wong                                                                                                                                                                                                                                                                                               |  |                                                                                         |  | Church Home Hospital                                                                  |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                               |  | 24B. DATE                                                                               |  | 24C. NAME of CEMETERY or CREMATORY                                                    |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                 |  | 9/11/72                                                                                 |  | St. Joseph Cemetery                                                                   |  | Mt. Carmel, North'd, Pa.                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR                                                                  |  | 25C. FUNERAL DIRECTOR                                                                 |  | ADDRESS                                                              |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                            |  | Audrey M. Wong                                                                          |  | Donovan Funeral Home                                                                  |  | 3818 Roland Ave.                                                     |  |



| STATE OF MARYLAND-DEMB                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--|--------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| REG. NO. 72 08644                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| BIRTH NO. E-300                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| 1. NAME OF DECEASED (Type or Print) George Clayton G. Eddy, Jr.                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                   |  |                                                                                                                                               | 2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 7 Year 72 Hour 5:05P.M. |                                                                                                                   |  |                    |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital                                                                                                                                                                                                                          |  |                                                                                                   |  |                                                                                                                                               | 3. DATE PRONOUNCED DEAD Month 9 Day 7 Year 72 Hour 5:05P.M.                                                                       |                                                                                                                   |  |                    |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Harford                                                                                                                                                                                                                                                                                     |  |                                                                                                   |  |                                                                                                                                               | C. CITY OR TOWN Edgewood D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |                                                                                                                   |  |                    |  |
| 6. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7. RACE White                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                   | E. STREET AND NUMBER 621 Mulberry Lane                                                                            |  |                    |  |
| 9. DATE OF BIRTH Feb. 27, 1953                                                                                                                                                                                                                                                                                                                                                                                |  | 10. AGE (in years lost birthday) 19                                                               |  | 11. BIRTHPLACE (State or foreign country) Ohio                                                                                                |                                                                                                                                   | 12. CITIZEN OF WHAT COUNTRY? USA                                                                                  |  |                    |  |
| 13. FATHER'S NAME Clayton George Eddy, Sr.                                                                                                                                                                                                                                                                                                                                                                    |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker |  | 15. MOTHER'S MAIDEN NAME Ida Leora Rawlins                                                                                                    |                                                                                                                                   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 70-71 |  |                    |  |
| 17. SOCIAL SECURITY NO. 219-58-0319                                                                                                                                                                                                                                                                                                                                                                           |  | 18. INFORMANT Clayton G. Eddy, Sr.                                                                |  | 19. CAUSE OF DEATH                                                                                                                            |                                                                                                                                   | 20. DATE OF OPERATION 2                                                                                           |  |                    |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Stab wound of chest                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                  |                                                                                                                                   | 21. AUTOPSY? (Yes or No) Yes                                                                                      |  |                    |  |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                               |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  |                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House    |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1811 Van Bibber Rd.                                                  |                                                                                                                                   | 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 9 7 72 4:20P.M.                                                   |  |                    |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                             |  | 22F. HOW DID INJURY OCCUR? stabbed during argument                                                |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                   |  |                                                                                                                                               |                                                                                                                                   |                                                                                                                   |  |                    |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.                                                                                                                                                                                                                                                                                                                                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                |                                                                                                                                   | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                               |  | DATE SIGNED 9-8-72 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                               |  | 24B. DATE Sept. 11, 1972                                                                          |  | 24C. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens, Aldino, Harford, Md.                                                             |                                                                                                                                   | 24D. LOCATION (City, town, or county) (State)                                                                     |  |                    |  |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR                                                                            |  | 25C. FUNERAL DIRECTOR ADDRESS Howard K. McComas, Abingdon, Md.                                                                                |                                                                                                                                   |                                                                                                                   |  |                    |  |







|                                 |  |               |  |               |  |          |  |        |  |
|---------------------------------|--|---------------|--|---------------|--|----------|--|--------|--|
| 1. Name of the person or entity |  | 2. Address    |  | 3. City       |  | 4. State |  | 5. Zip |  |
| John Doe                        |  | 123 Main St   |  | New York      |  | NY       |  | 10001  |  |
| Jane Smith                      |  | 456 Elm St    |  | Los Angeles   |  | CA       |  | 90001  |  |
| ABC Company                     |  | 789 Market St |  | San Francisco |  | CA       |  | 94102  |  |
| XYZ Corp                        |  | 101 Broadway  |  | New York      |  | NY       |  | 10003  |  |
| DEF Inc                         |  | 202 Park Ave  |  | New York      |  | NY       |  | 10003  |  |
| GHI LLC                         |  | 303 Wall St   |  | New York      |  | NY       |  | 10005  |  |
| JKL Partners                    |  | 404 Nassau St |  | New York      |  | NY       |  | 10002  |  |
| MNO Group                       |  | 505 Broadway  |  | New York      |  | NY       |  | 10003  |  |
| PQR Ventures                    |  | 606 Broadway  |  | New York      |  | NY       |  | 10003  |  |
| STU Capital                     |  | 707 Broadway  |  | New York      |  | NY       |  | 10003  |  |
| VWX Holdings                    |  | 808 Broadway  |  | New York      |  | NY       |  | 10003  |  |
| YZA Investments                 |  | 909 Broadway  |  | New York      |  | NY       |  | 10003  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

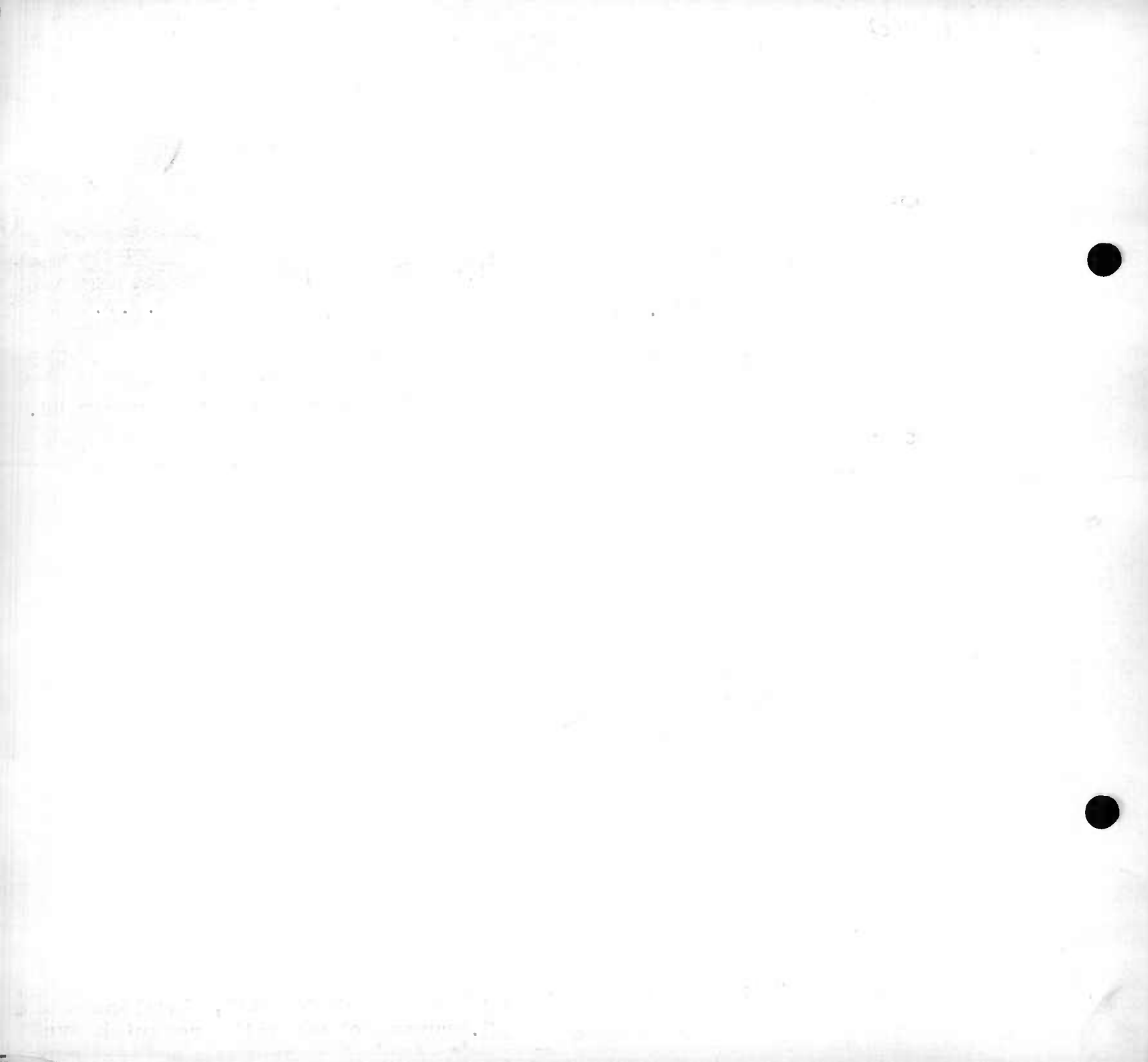
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                               |  |                                                                                                        |                                                                                                                                            | REG. NO. <b>72 08646</b>                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--|
| A-252 72 08646                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                                                                                            | BIRTH NO.                                                                   |  |
| 72 08646                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |                                                                                                                                            | STATE OF MARYLAND - DEATH                                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Frank T. Asencio</b>                                                                                                                                                                                                                                                              |  |                                                                                                        | 2. DATE AND HOUR OF DEATH<br><b>Sept. 5, 1972</b>                                                                                          |                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 Union Memorial Hospital</b>                                                                                                                   |  |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2102</b> |                                                                             |  |
| 5. SEX <b>male</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                        | 6. RACE <b>Caucasian</b>                                                                                                                   |                                                                             |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                    |  |                                                                                                        | 8. DATE OF BIRTH <b>Dec. 17, 1908</b>                                                                                                      |                                                                             |  |
| 9. AGE (In years last birthday) <b>63 yrs.</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                        | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Musician</b>                                 |                                                                             |  |
| 11. BIRTHPLACE (State or foreign country) <b>Porta Rico</b>                                                                                                                                                                                                                                                                    |  |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                 |                                                                             |  |
| 13. FATHER'S NAME <b>Jose Suri Asencio</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                        | 14. MOTHER'S MAIDEN NAME <b>Oliva Suri</b>                                                                                                 |                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no none</b>                                                                                                                                                                                                     |  |                                                                                                        | 16. SOCIAL SECURITY NO. <b>115-228703</b>                                                                                                  |                                                                             |  |
| 17. INFORMANT <b>Gertrude Asencio</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                        | ADDRESS <b>1153 W. Cross St.</b>                                                                                                           |                                                                             |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>410.9 I</b><br><b>Acute Myocardial Infarction</b>                                                                     |  |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>                                                                             |                                                                             |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>ASHD</b>                                                                                                                                                                              |  |                                                                                                        | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>-</b>                                                                                            |                                                                             |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>-</b>                                                                                                                                                                                                                                                                                |  |                                                                                                        |                                                                                                                                            |                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                               |  |                                                                                                        |                                                                                                                                            |                                                                             |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                            | 20A. AUTOPSY? (Yes or No) <b>No</b>                                         |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                 |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                                                                                                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)    |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                      |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                            | 21F. HOW DID INJURY OCCUR?                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Nov 1970</b> to <b>Sept 1972</b> , that (I) (we) last saw the deceased alive on <b>8/22 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |                                                                                                                                            |                                                                             |  |
| 23A. SIGNATURE <b>Robert I. Leary</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                        |                                                                                                                                            | 23B. DATE SIGNED <b>11/6/72</b>                                             |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Robert I. Leary</b>                                                                                                                                                                                                                                                                            |  |                                                                                                        |                                                                                                                                            | 23D. ADDRESS <b>114 Medical Arts Bldg. Baltimore Md</b>                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                         |  | 24B. DATE <b>9/9/72</b>                                                                                |                                                                                                                                            | 24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>                        |  |
| 24D. LOCATION (City, town, or county) <b>Ritchie Highway A.A.Ct.Md.</b>                                                                                                                                                                                                                                                        |  | 24E. (State) <b>Md.</b>                                                                                |                                                                                                                                            |                                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 11 1972</b>                                                                                                                                                                                                                                                                             |  | 25B. NAME OF REGISTRAR <b>Schweinsberg</b>                                                             |                                                                                                                                            | 25C. FUNERAL DIRECTOR ADDRESS <b>Schweinsberg Fun Service 1126 W. Cross</b> |  |



# FUNERAL DIRECTOR: IMPORTANT

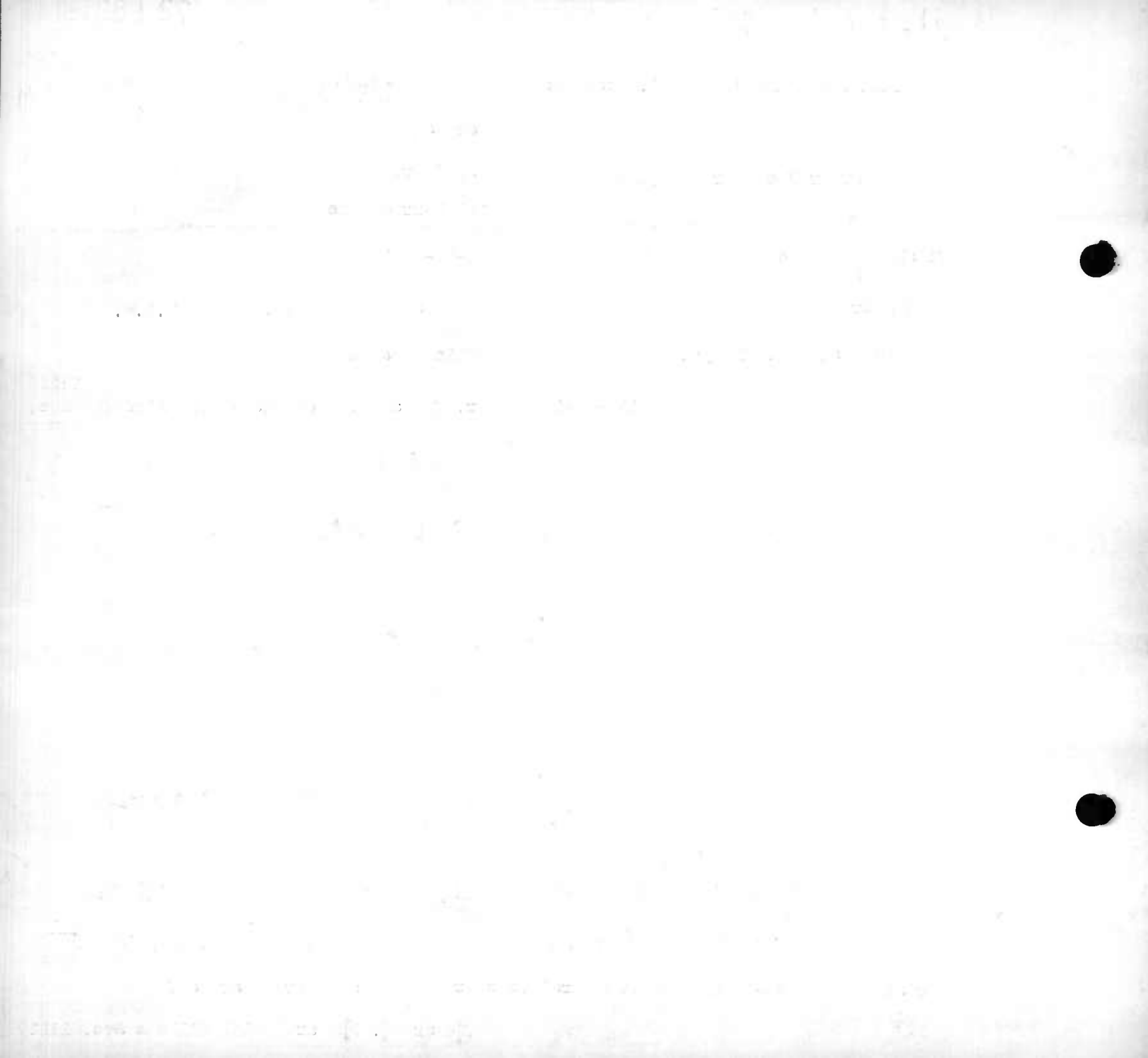
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                    | REG. NO. 72 08647                                                                                  |                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 72 08647                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |                                    | CERTIFICATE OF DEATH                                                                               |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>DELL, John C.</b>                                                                                                                                                                                                                                                                                                                                                                                            |                     | 2. DATE AND HOUR OF DEATH<br><b>9/4/72-6:45 AM</b>                                                                                                          |                                    |                                                                                                    |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                 |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                                    |                                                                                                    |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>42 Sinai Hospital<br/>Belvedere &amp; Greenspring Ave<br/>Baltimore, Maryland, 21215</b>                                                                                                                                                                                                                                                                                                                    |                     | A. STATE<br><b>B. COUNTY</b>                                                                                                                                |                                    | <b>616 Beverly Road 5300</b>                                                                       |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | C. CITY OR TOWN<br><b>Reisterstown, Md.</b>                                                                                                                 |                                    | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | E. STREET AND NUMBER                                                                                                                                        |                                    |                                                                                                    |                                                           |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/23/96</b> | 9. AGE (In years lost birthday)<br><b>76</b>                                                       | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Driver</b>                                                                                                                                                                                                                                                                                                                                           |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Transit</b>                                                                                                  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                       |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                     | 13. FATHER'S NAME<br><b>Francis Dell</b>                                                                                                                    |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Penelope Reece</b>                                                  |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                 |                     | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                    | 17. INFORMANT<br><b>Schaeffer</b><br><b>Mrs Evelyn Schaeffer</b> ADDRESS<br><b>611 Beverly Rd.</b> |                                                           |
| 18. <b>5/9/21</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>Myocardial Infarction.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Congestive Heart Failure.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Coronary Lesion of Lung.</b> |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                    |                                                                                                    |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |                                    |                                                                                                    |                                                           |
| 19A. DATE OF OPERATION<br><b>5/9/21</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)                                                                          |                                                           |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                                                                |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                        |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                              |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                                         |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>September 27, 1972</b> to <b>September 4, 1972</b> that (I) (we) last saw the deceased alive on <b>September 4, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                 |                     |                                                                                                                                                             |                                    |                                                                                                    |                                                           |
| 23A. SIGNATURE<br><b>Robert Kroppnick, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |                                    | 23B. DATE SIGNED<br><b>9/4/72</b>                                                                  |                                                           |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                           |                     | 23D. ADDRESS                                                                                                                                                |                                    |                                                                                                    |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                              |                     | 24B. DATE<br><b>9/7/1972</b>                                                                                                                                |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Greenmount Cemetery</b>                                   |                                                           |
| 24D. LOCATION<br><b>Greenmount, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                       |                                    |                                                                                                    |                                                           |
| 25B. NAME OF REGISTRAR<br><b>Sidney W. H. H. H.</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                     | 25C. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b> ADDRESS<br><b>3512 Frederick Ave</b>                                                                       |                                    |                                                                                                    |                                                           |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                |                                                                                                                                                                                                                                                                                                   |                                           |                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------|--|
| W-364                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 72 08648                                                                                                                                                    |                                | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                  |                                           | 72 08648                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             |                                | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                              |                                           |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><del>W. Weatherall</del> Mary K. Weatherall                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                | 2. DATE AND HOUR OF DEATH<br>9/3/72 1:30 A.M.                                                                                                                                                                                                                                                     |                                           |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>90 Harbor View Nursing Home                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                             |                                | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY 2005<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 307 Furrow Street |                                           |                                                                      |  |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>11-27-1902 | 9. AGE (In years last birthday)<br>69                                                                                                                                                                                                                                                             | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min.                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Homemaker                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                | 11. BIRTHPLACE (State or foreign country)<br>Washington, D.C.                                                                                                                                                                                                                                     |                                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                               |  |
| 13. FATHER'S NAME<br>Reginal E. Pumphrey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                | 14. MOTHER'S MAIDEN NAME<br>Ellen Bailey                                                                                                                                                                                                                                                          |                                           |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 16. SOCIAL SECURITY NO.<br>218-09-2098B                                                                                                                     |                                | 17. INFORMANT ADDRESS 21228<br>Mr. Thomas F. Weatherall, 227 Altamont Ave.                                                                                                                                                                                                                        |                                           |                                                                      |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>4/12/81<br>Terminal Pulmonary Disease<br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) A.S.C.V. Disease DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Hypertension DUE TO, OR AS A CONSEQUENCE OF:<br>CVA - Left Hemiparesis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>?<br>?<br>? |                  |                                                                                                                                                             |                                |                                                                                                                                                                                                                                                                                                   |                                           |                                                                      |  |
| 19. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                  |                                           | 20A. AUTOPSY (Yes or No)<br>No                                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                          |                                           |                                                                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                        |                                           |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 5/19 19 71 to 9/3/72 19 72 that (I) (we) last saw the deceased alive on 9/2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                                |                                                                                                                                                                                                                                                                                                   |                                           |                                                                      |  |
| 23A. SIGNATURE<br>Joseph S. Blum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |                                | 23B. DATE SIGNED<br>9/5/72                                                                                                                                                                                                                                                                        |                                           | 23C. PHYSICIAN'S NAME (Type)<br>JOSEPH S. BLUM                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 24B. DATE<br>9-6-1972                                                                                                                                       |                                | 24C. NAME OF CEMETERY or CREMATORY<br>New Cathedral Cemetery                                                                                                                                                                                                                                      |                                           | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 25B. NAME OF REGISTRAR<br>Sidney H. Hubbert                                                                                                                 |                                | 25C. FUNERAL DIRECTOR<br>Howard H. Hubbard                                                                                                                                                                                                                                                        |                                           | 25D. ADDRESS<br>4107 Wilkens Ave. 21229                              |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                     |           |                                                                                          |                                                                                      | REG. NO. 72 08619                                                         |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------|
| J-520 72 08619                                                                                                                                                                                                                                                                                                                       |           |                                                                                          |                                                                                      | STATE OF MARYLAND-DUMF                                                    |                                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                            |           | 1. NAME OF DECEASED<br>(Type or Print)                                                   |                                                                                      | 2. DATE AND HOUR OF DEATH                                                 |                                                          |
|                                                                                                                                                                                                                                                                                                                                      |           | JONES, RALPH                                                                             |                                                                                      | SEPTEMBER 5, 1972 10:30A M.                                               |                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                               |           |                                                                                          | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) |                                                                           |                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                         |           |                                                                                          | A. STATE B. COUNTY                                                                   |                                                                           |                                                          |
| 40 ST. AGNES HOSPITAL                                                                                                                                                                                                                                                                                                                |           |                                                                                          | MARYLAND BALTO 5300                                                                  |                                                                           |                                                          |
|                                                                                                                                                                                                                                                                                                                                      |           |                                                                                          | C. CITY OR TOWN                                                                      |                                                                           | D. INSIDE CITY LIMITS?                                   |
|                                                                                                                                                                                                                                                                                                                                      |           |                                                                                          | ARBUSUS                                                                              |                                                                           | YES <input type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                      |           |                                                                                          | E. STREET AND NUMBER                                                                 |                                                                           |                                                          |
|                                                                                                                                                                                                                                                                                                                                      |           |                                                                                          | 4202 MARYLAND PLACE 21229                                                            |                                                                           |                                                          |
| 5. SEX                                                                                                                                                                                                                                                                                                                               | 6. RACE   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH                                                                     | 9. AGE (In years lost birthday)                                           | If Under 1 Yr. Months Days                               |
| MALE                                                                                                                                                                                                                                                                                                                                 | CAUCASIAN | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 07/13/98                                                                             | 75                                                                        |                                                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                          |           | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                                                                                      | 11. BIRTHPLACE (State or foreign country)                                 |                                                          |
| Retired                                                                                                                                                                                                                                                                                                                              |           | TRAILER COMPANY                                                                          |                                                                                      | ILLINOIS                                                                  |                                                          |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                    |           | 14. MOTHER'S MAIDEN NAME                                                                 |                                                                                      | 12. CITIZEN OF WHAT COUNTRY?                                              |                                                          |
| JOHN JONES                                                                                                                                                                                                                                                                                                                           |           | CHARLOTTE (UNKNOWN)                                                                      |                                                                                      | U.S.A.                                                                    |                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                             |           | 16. SOCIAL SECURITY NO.                                                                  |                                                                                      | 17. INFORMANT ADDRESS                                                     |                                                          |
| NONE                                                                                                                                                                                                                                                                                                                                 |           | 023-10-7925                                                                              |                                                                                      | Mrs. Venus H. Jones, 4202 Maryland Place ST. AGNES HOSPITAL RECORDS 21229 |                                                          |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |           |                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                         |                                                                           |                                                          |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                       |           |                                                                                          |                                                                                      |                                                                           |                                                          |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                         |           |                                                                                          |                                                                                      |                                                                           |                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                    |           |                                                                                          |                                                                                      |                                                                           |                                                          |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                            |           |                                                                                          |                                                                                      |                                                                           |                                                          |
| II                                                                                                                                                                                                                                                                                                                                   |           |                                                                                          |                                                                                      |                                                                           |                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                     |           |                                                                                          |                                                                                      |                                                                           |                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                                                                                      | 20A. AUTOPSY? (Yes or No)                                                 |                                                          |
| 2                                                                                                                                                                                                                                                                                                                                    |           |                                                                                          |                                                                                      | YES                                                                       |                                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                                                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                                          |
|                                                                                                                                                                                                                                                                                                                                      |           |                                                                                          |                                                                                      |                                                                           |                                                          |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                        |           | 21E. INJURY OCCURRED                                                                     |                                                                                      | 21F. HOW DID INJURY OCCUR?                                                |                                                          |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                          |           | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                                                                                      |                                                                           |                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 03 19 72 to SEPTEMBER 05 19 72, that (I) (we) last saw the deceased alive on SEPTEMBER 05 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |           |                                                                                          |                                                                                      |                                                                           |                                                          |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                       |           |                                                                                          |                                                                                      | 23B. DATE SIGNED                                                          |                                                          |
| AGATON H. ESCOBARTE, M.D.                                                                                                                                                                                                                                                                                                            |           |                                                                                          |                                                                                      | 9/6/72                                                                    |                                                          |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                         |           |                                                                                          |                                                                                      | 23D. ADDRESS                                                              |                                                          |
|                                                                                                                                                                                                                                                                                                                                      |           |                                                                                          |                                                                                      | BALTIMORE, MARYLAND 21229                                                 |                                                          |
|                                                                                                                                                                                                                                                                                                                                      |           |                                                                                          |                                                                                      | ST. AGNES HOSPITAL; CATON & WILKENS AVE.                                  |                                                          |
| 24A. BURIAL CREMATION REMOVAL (Specify)                                                                                                                                                                                                                                                                                              |           | 24B. DATE                                                                                |                                                                                      | 24C. NAME of CEMETERY or CREMATORY                                        |                                                          |
| Burial                                                                                                                                                                                                                                                                                                                               |           | 9-7-1972                                                                                 |                                                                                      | Cem. Taylorsville United Meth. Ch.                                        |                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                      |           | 25B. NAME OF REGISTRAR                                                                   |                                                                                      | 25C. FUNERAL DIRECTOR ADDRESS                                             |                                                          |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                          |           | Sidney H. Hubbard                                                                        |                                                                                      | Howard H. Hubbard, 4107 Wilkens Avenue 21229                              |                                                          |

10-00A

SEPTEMBER 8, 1973

11:00A

MARYLAND

ST. AGNES HOSPITAL

2005 MARYLAND BLVD. BALTIMORE

ST. AGNES HOSPITAL

73

NAME: CANAZIAN

ILLINOIS

TRAILER COMPANY

11-00A

JOHN JONES

GREEN

003-10-7322 ST. AGNES HOSPITAL RECORDS

11-00A

YES

SEPTEMBER 02 73  
SEPTEMBER 02 73

ST. AGNES HOSPITAL, CATON & WICKENS DR.  
BALTIMORE, MARYLAND 21228

11-00A

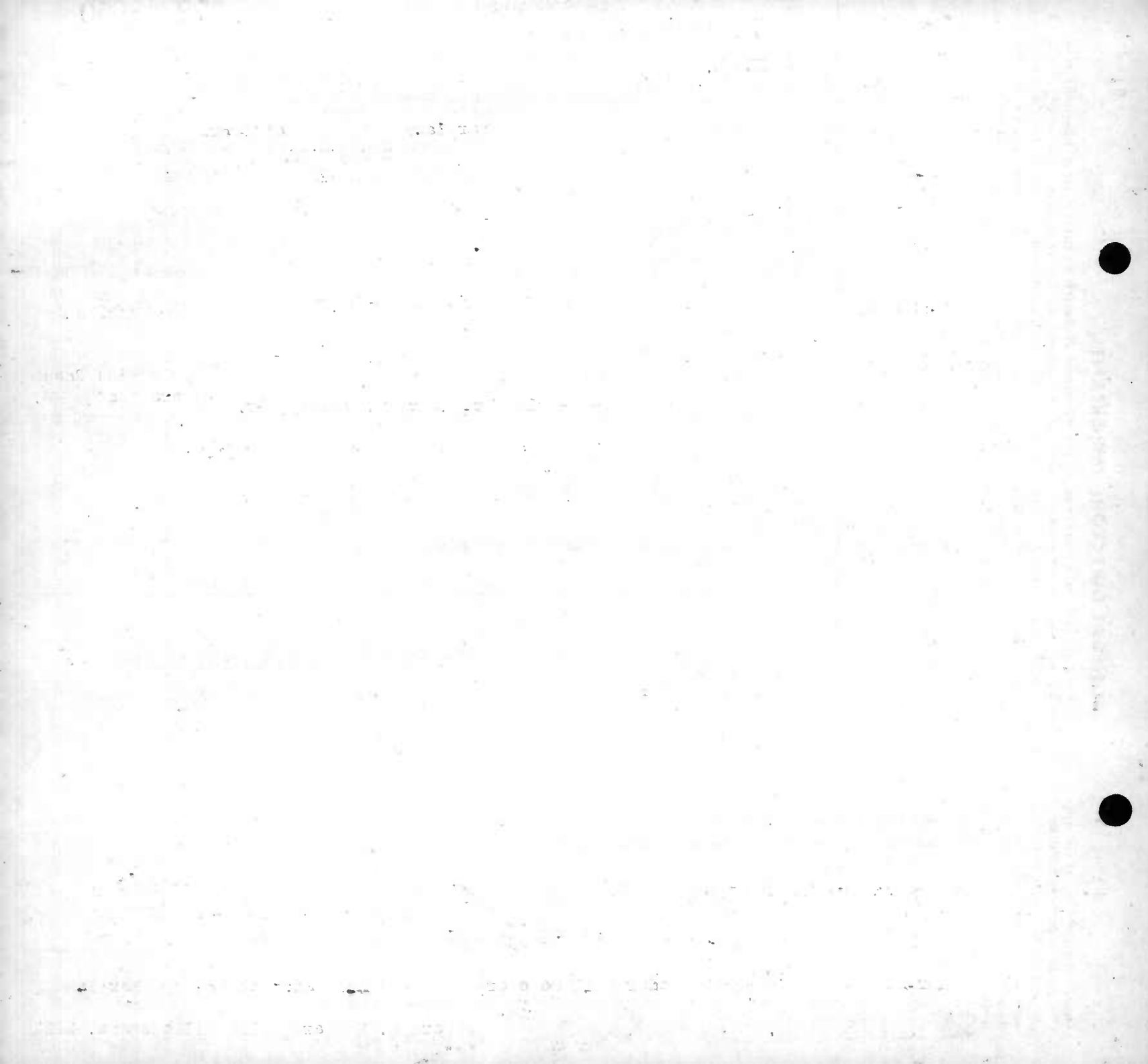
SEP 11 1973



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                             |                               |                                                                                                                        |                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                             |              | 72 08650                                                                                                                                                    |                               | REG. NO. 72 08650                                                                                                      |                                                               |
| U-320                                                                                                                                                                                                                                                                                                                                                                                        |              | 72 08650                                                                                                                                                    |                               | STATE OF MARYLAND-DHMT                                                                                                 |                                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                    |              | 1. NAME OF DECEASED<br>(Type or Print) LUCILE L. <del>XXXXXXXXXX</del> UTZ                                                                                  |                               | 2. DATE AND HOUR OF DEATH<br>SEPT. 3 1972 6:30 A.M.                                                                    |                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                       |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore                              |                               | 5. CITY OR TOWN CATONSVILLE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Caton Manor Nursing Center                                                                                                                                                                                                                                                      |              | E. STREET AND NUMBER<br>324 Graham Rd                                                                                                                       |                               | F. ZIP CODE<br>21228                                                                                                   |                                                               |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                  | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>7/30/1911 | 9. AGE (In years last birthday)<br>61                                                                                  | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Homemaker.                                                                                                                                                                                                                                                                                    |              | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                               | 11. BIRTHPLACE (State or foreign country)<br>New York                                                                  |                                                               |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                       |              | 13. FATHER'S NAME<br>Henry C. Velten, Sr.                                                                                                                   |                               | 14. MOTHER'S MAIDEN NAME<br>Bertha Velten                                                                              |                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                               |              | 16. SOCIAL SECURITY NO.<br>217-05-6019                                                                                                                      |                               | 17. INFORMANT<br>Mr. Henry C. Velten, Jr.                                                                              |                                                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>GENERALIZED CA, PRIMARY<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>ORIGIN - CA OF BREAST<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                               |                                                                                                                        |                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                       |              |                                                                                                                                                             |                               |                                                                                                                        |                                                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                               | 20A. AUTOPSY? (Yes or No)                                                                                              |                                                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                      |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                               |                                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                    |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                               | 21F. HOW DID INJURY OCCUR?                                                                                             |                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                         |              |                                                                                                                                                             |                               |                                                                                                                        |                                                               |
| 23A. SIGNATURE<br>D. Sorongon M.D.                                                                                                                                                                                                                                                                                                                                                           |              | 23B. DATE SIGNED<br>9/3/72                                                                                                                                  |                               | 23C. PHYSICIAN'S NAME (Type)<br>DOMINGO C. SORONGON M.D.                                                               |                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                           |              | 24B. DATE<br>9-7-1972                                                                                                                                       |                               | 24C. NAME of CEMETERY or CREMATORY<br>Cedar Hill Cemetery                                                              |                                                               |
| 24D. LOCATION<br>Anne Arundel County, Maryland                                                                                                                                                                                                                                                                                                                                               |              | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                              |                               | 25B. NAME OF REGISTRAR<br>Sidney White                                                                                 |                                                               |
| 25C. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229                                                                                                                                                                                                                                                                                                                          |              | 25D. ADDRESS                                                                                                                                                |                               | 25E. ADDRESS                                                                                                           |                                                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                            |  |                                                                                          |  | REG. NO. 72 08651                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|
| 72 08651                                                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | CERTIFICATE OF DEATH                                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                      |  | 2. DATE AND HOUR OF DEATH                                                                |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                    |  |
| DISTEFANO, EVELYN E.                                                                                                                                                                                                                                                                                                        |  | SEPTEMBER 3, 1972 8:30A.M.                                                               |  | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |  |
| 40 ST. AGNES HOSPITAL                                                                                                                                                                                                                                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |  | 5. SEX                                                                                                    |  |
| MARYLAND CITY 21223                                                                                                                                                                                                                                                                                                         |  | A. STATE B. COUNTY                                                                       |  | FEMALE CAUCASIAN                                                                                          |  |
| C. CITY OR TOWN                                                                                                                                                                                                                                                                                                             |  | D. INSIDE CITY LIMITS?                                                                   |  | 6. RACE                                                                                                   |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  | CAUCASIAN                                                                                                 |  |
| E. STREET AND NUMBER                                                                                                                                                                                                                                                                                                        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    |  | 8. DATE OF BIRTH                                                                                          |  |
| 2105 CHRISTIAN ST. 2005                                                                                                                                                                                                                                                                                                     |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  | 03 05 10                                                                                                  |  |
| 9. AGE (In years last birthday)                                                                                                                                                                                                                                                                                             |  | 10. KIND OF BUSINESS OR INDUSTRY                                                         |  | 11. BIRTHPLACE (State or foreign country)                                                                 |  |
| 62                                                                                                                                                                                                                                                                                                                          |  | Homemaker                                                                                |  | MARYLAND                                                                                                  |  |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                |  | 13. FATHER'S NAME                                                                        |  | 14. MOTHER'S MAIDEN NAME                                                                                  |  |
| U.S.A.                                                                                                                                                                                                                                                                                                                      |  | CHARLES SHELTON                                                                          |  | EFFIE (SWANN)                                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO.                                                                  |  | 17. INFORMANT                                                                                             |  |
| No                                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | RECORDS OF ST. AGNES HOSPITAL<br>CATON & WILKENS AVES. BALTO., MD. 21229                                  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                          |  |                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                              |  |
| (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                               |  |                                                                                          |  | 5 day                                                                                                     |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                           |  |                                                                                          |  |                                                                                                           |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                   |  |                                                                                          |  |                                                                                                           |  |
| II                                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  |                                                                                                           |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                            |  |                                                                                          |  |                                                                                                           |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                          |  | NO                                                                                                        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)                                  |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                          |  |                                                                                                           |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                               |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                 |  | While At <input type="checkbox"/> Nat While <input type="checkbox"/><br>Work At Work     |  |                                                                                                           |  |
| 22. I certify that (X) (this hospital) attended the deceased from AUGUST 29 1972 to SEPTEMBER 3 1972, that (X) (we) last saw the deceased alive on SEPTEMBER 3 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                                                           |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                              |  |                                                                                          |  | 23B. DATE SIGNED                                                                                          |  |
| HARJIT SINGH, M.D.                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | 9-3-72                                                                                                    |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                |  |                                                                                          |  | 23D. ADDRESS                                                                                              |  |
| HARJIT SINGH, M.D.                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | CATON & WILKENS AVES. BALTO., MD. 21229                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                    |  | 24B. DATE                                                                                |  | 24C. NAME of CEMETERY or CREMATORY                                                                        |  |
| Burial                                                                                                                                                                                                                                                                                                                      |  | 9-7-1972                                                                                 |  | Glen Haven Cemetery                                                                                       |  |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                               |  | 24E. DATE REC'D BY HEALTH DEPT.                                                          |  | 24F. NAME OF REGISTRAR                                                                                    |  |
| Glen Burnie, Anne Arundel Co., Md.                                                                                                                                                                                                                                                                                          |  | SEP 11 1972                                                                              |  | Howard H. Hubbard, 4107 Wilkens Ave. 21229                                                                |  |

WISTENBERG, EVELYN E. SEPTEMBER 3, 1973 8:30A

MARYLAND CITY 21523

X

BALTIMORE

ST. AGNES HOSPITAL

2102 CHRISTIAN ST.

X

FEMALE CAUCASIAN

03 02 10 63

MARYLAND

EEFEE (S) (M)

CHARLES SHELTON

RECORDS OF ST. AGNES HOSPITAL  
CATON & WILKINS AVES. BALTO., MD. 21202

NO

AUGUST 29 73 SEPTEMBER 3 73 X

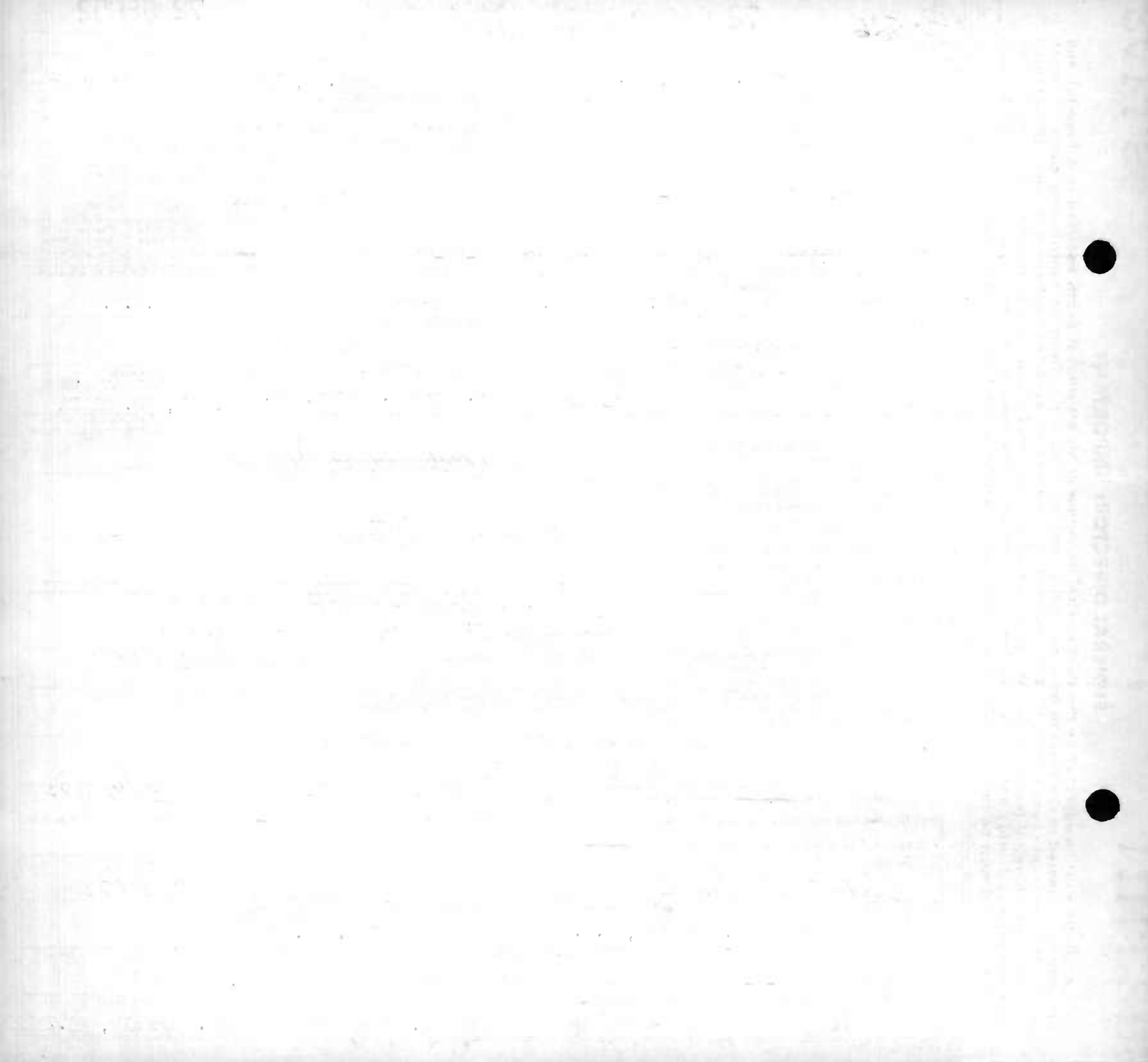
CATON & WILKINS AVES. BALTO., MD. 21202

HARLIT SINGH, M.D.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

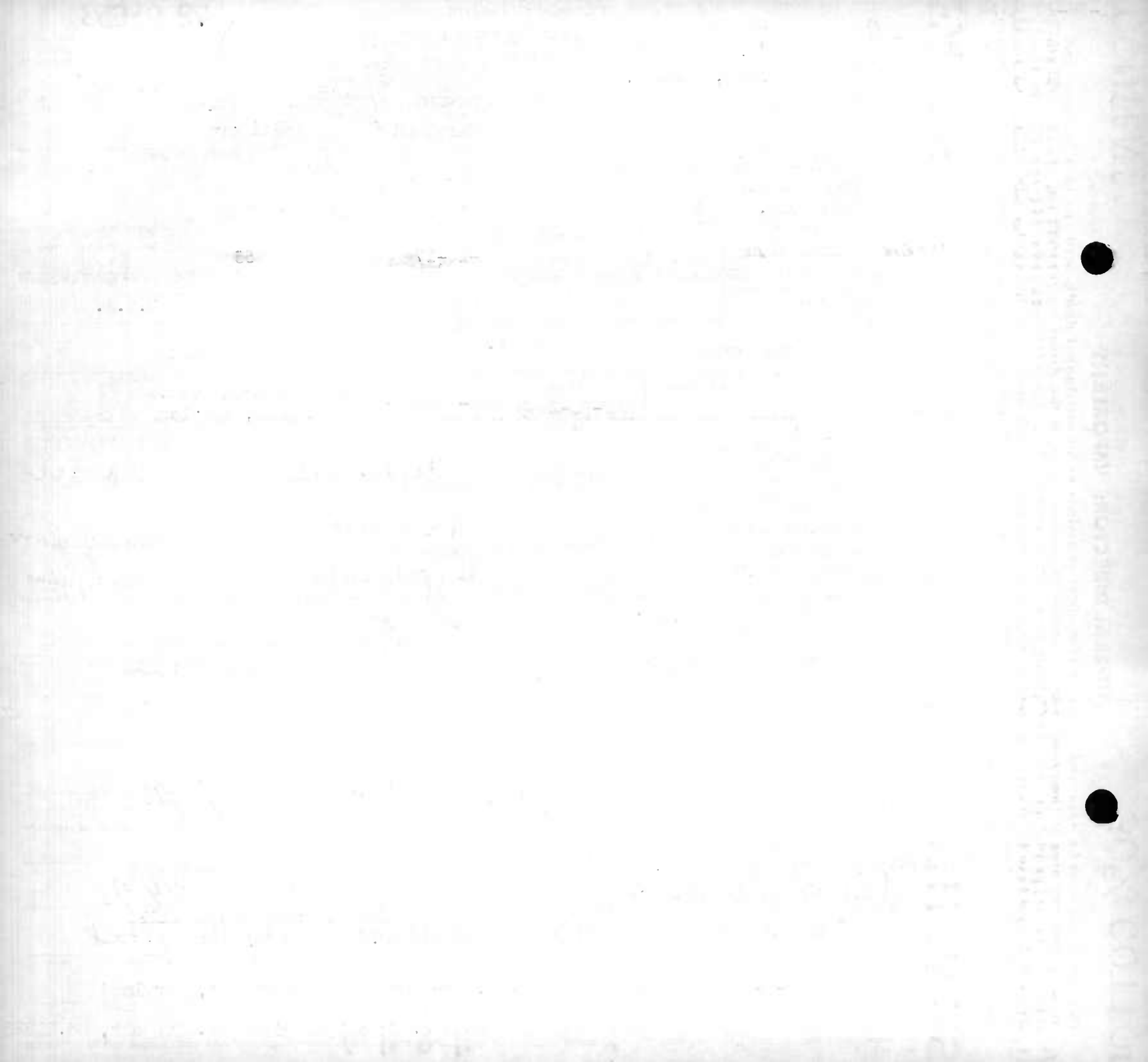
| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                  |  | 72 08652                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 72 08652                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <span style="float: right;">Noah E. Ensor, Sr.</span>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                  |  | <b>2. DATE AND HOUR OF DEATH</b><br>Sept. 4, 1972 <span style="float: right;">4:40 P.M.</span>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                               |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 2em; float: left; margin-right: 10px;">90</span> House in the Pines-Belair                                                                                                                               |  |                                                                                                                  |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution residence before admission)<br><b>A. STATE</b> <span style="float: right;">Maryland</span> <b>B. COUNTY</b> <span style="float: right;">Baltimore</span><br><b>C. CITY OR TOWN</b> <span style="float: right;">Dundalk</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br><b>E. STREET AND NUMBER</b> <span style="float: right;">1928 August Avenue</span> |  |                                                                               |  |
| <b>5. SEX</b><br>Male                                                                                                                                                                                                                                                                                                                                                                                                     |  | <b>6. RACE</b><br>White                                                                                          |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  | <b>8. DATE OF BIRTH</b><br>3-25-81                                            |  |
| <b>9. AGE</b> (In years last birthday)<br>91                                                                                                                                                                                                                                                                                                                                                                              |  | <b>10. UNDER 1 Yr.</b><br>Months: Days:                                                                          |  | <b>11. UNDER 24 Hrs.</b><br>Hours: Min.                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                               |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Retired                                                                                                                                                                                                                                                                                                             |  |                                                                                                                  |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br>Beth. Steel Co.                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br>Maryland                  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                               |  |
| <b>13. FATHER'S NAME</b><br>Franklin Ensor                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                  |  | <b>14. MOTHER'S MAIDEN NAME</b><br>Rickey ?                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                               |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                  |  | <b>16. SOCIAL SECURITY NO.</b><br>213-07-1876                                                                    |  | <b>17. INFORMANT</b> Son: <span style="float: right;">1928 August Avenue</span><br>Mr. Noah E. Ensor, Jr. <span style="float: right;">Dundalk, Md. 21222</span>                                                                                                                                                                                                                                                                                                                      |  |                                                                               |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                        |  |                                                                                                                  |  | <b>CAUSE OF DEATH</b><br><b>(A) IMMEDIATE CAUSE</b> <i>Arteriosclerotic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(B) <i>Generalized Arteriosclerosis</i></b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(C) <i>Cerebrovascular Disease; Diabetes mellitus; Rheumatoid arthritis; Adenoma of pituitary; multiple metastases; Emphysema;</i></b>                                                                                                                       |  |                                                                               |  |
| <b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><i>hours.</i><br><i>years</i>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                               |  |
| <b>19A. DATE OF OPERATION</b><br>9/12/72                                                                                                                                                                                                                                                                                                                                                                                  |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                          |  | <b>20A. AUTOPSY?</b> (Yes or No)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>   |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                               |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                          |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                               |  |
| <b>22. I certify that (I) (<del>this hospital</del>) attended the deceased from</b> <u>8/12/1972</u> <b>to</b> <u>9/4/1972</u><br><b>that (I) (<del>we</del>) last saw the deceased alive on</b> <u>8/29/1972</u> <b>and that (my) (<del>our</del>) opinion death occurred on the date</b><br><b>and hour and from the causes stated above, (I) (<del>we</del>) (<del>did</del>) (did not) view the body after death.</b> |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                               |  |
| <b>23A. SIGNATURE</b><br><i>Albert B. Bradley</i>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                  |  | <b>23B. DATE SIGNED</b><br>9/6/72                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | <b>23C. PHYSICIAN'S NAME</b> (Type)<br>Albert B. Bradley, M.D.                |  |
| <b>23D. ADDRESS</b><br>4900 Belair Road<br>Balto. Md. 21206                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                               |  |
| <b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b><br>Burial                                                                                                                                                                                                                                                                                                                                                                |  | <b>24B. DATE</b><br>9-7-72                                                                                       |  | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br>Glen Haven Memorial Park                                                                                                                                                                                                                                                                                                                                                                                                                |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br>Glen Burnie, Maryland |  |
| <b>25A. DATE REC'D BY HEALTH DEPT</b><br>SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                      |  | <b>25B. NAME OF REGISTRAR</b><br><i>Dorothy H. Hinton</i>                                                        |  | <b>25C. FUNERAL DIRECTOR</b> <span style="float: right;">ADDRESS</span><br>John J. Ruda 7922 Wise Ave. Dundalk, Md. 21222                                                                                                                                                                                                                                                                                                                                                            |  |                                                                               |  |



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                           |  |          |  |                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. <b>S-326</b>                                                                                                                                                    |  | 72 08653 |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                        |  | REG. NO. <b>72 08653</b>                                                                                                                         |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Staiger, Jane I.</b>                                                                                                            |  |          |  | 2. DATE AND HOUR OF DEATH<br><b>9/4/72 12:45 a.m.</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                    |  |          |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue</b><br><b>Baltimore, Maryland 21224</b>                                 |  |          |  | A. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                             |  | B. COUNTY<br><b>Baltimore</b>                                                                                                                    |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                   |  |          |  | 6. RACE<br><b>Caucasian</b>                                                                                                                                                                                                                                                                                                             |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>4-26-17</b>                                                                                                                                        |  |          |  | 9. AGE (in years last birthday)<br><b>55</b>                                                                                                                                                                                                                                                                                            |  | 10. If Under 1 Yr. Months: Days: Hours: Min.                                                                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                           |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                       |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                             |  |          |  | 13. FATHER'S NAME<br><b>Ross Borne</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Elsie Chaney</b>                                                                                                                           |  |          |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                   |  |                                                                                                                                                  |  |
| 16. SOCIAL SECURITY NO.<br><b>218-36-2493</b>                                                                                                                             |  |          |  | 17. INFORMANT<br><b>BCH-Records</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  |
| 18. ADDRESS<br><b>4940 Eastern Avenue</b><br><b>Baltimore, Maryland 21224</b>                                                                                             |  |          |  | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>Acute MI</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  |
| 20. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>ASCVD</b><br><b>Hypertension</b> |  |          |  | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 hours</b><br><b>many years</b><br><b>many years</b>                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>XX</b>                         |  |          |  | 23. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  |
| 24. DATE OF OPERATION<br><b>9/4/72</b>                                                                                                                                    |  |          |  | 25. DATE OF OPERATION FOR WHICH OPERATION WAS PERFORMED<br><b>9/4/72</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |
| 26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                          |  |          |  | 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>NO</b>                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |
| 28. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br><b>9/3 11:15 pm 72</b>                                                                                        |  |          |  | 29. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |
| 30. HOW DID INJURY OCCUR?<br><b>9/4/72</b>                                                                                                                                |  |          |  | 31. I certify that (I) (this hospital) attended the deceased from <b>9/3 11:15 pm 72</b> to <b>9/4/72</b> and that (I) (we) last saw the deceased alive on <b>9/4 12:45 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                  |  |
| 32. SIGNATURE<br><b>David L. Curtis MD</b>                                                                                                                                |  |          |  | 33. DATE SIGNED<br><b>9/4/72</b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 34. PHYSICIAN'S NAME (Type)<br><b>DAVID L. Curtis MD</b>                                                                                                                  |  |          |  | 35. ADDRESS<br><b>4940 Eastern Avenue 21224</b><br><b>Baltimore City Hospital</b>                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |
| 36. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                  |  |          |  | 37. DATE<br><b>9-7-72</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  |
| 38. NAME of CEMETERY or CREMATORY<br><b>Dulaney Valley Mem. Gardens</b>                                                                                                   |  |          |  | 39. LOCATION (City, town, & county) (State)<br><b>Cockeysville, Maryland</b>                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |
| 40. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                      |  |          |  | 41. NAME OF REGISTRAR<br><b>John J. Duda</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |
| 42. FUNERAL DIRECTOR<br><b>John J. Duda</b>                                                                                                                               |  |          |  | 43. ADDRESS<br><b>7922 Wise Ave. Dundalk, Md. 21222</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                 |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| M-625                                                                                                                                                                                                                                                                                                           |  | 72 08654                                                                                |  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |  | 72 08654                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                       |  |                                                                                         |  | REG. NO.                                                                              |  |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                          |  |                                                                                         |  | 2. DATE AND HOUR OF DEATH                                                             |  |                                                                      |  |
| L. Jerry Morgan                                                                                                                                                                                                                                                                                                 |  |                                                                                         |  | 9/3/72 7:45 P.M.                                                                      |  |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                          |  |                                                                                         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |                                                                      |  |
| FULL NAME OF DECEASED<br>HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                |  |                                                                                         |  | A. STATE B. COUNTY                                                                    |  |                                                                      |  |
| 4940 Eastern Avenue, Baltimore, Md.<br>Baltimore City Hospitals                                                                                                                                                                                                                                                 |  |                                                                                         |  | Maryland Baltimore                                                                    |  |                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                          |  |                                                                                         |  | 6. RACE                                                                               |  |                                                                      |  |
| Male                                                                                                                                                                                                                                                                                                            |  |                                                                                         |  | Caucasian                                                                             |  |                                                                      |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>                                                                                                                                                                                                                           |  |                                                                                         |  | 8. DATE OF BIRTH                                                                      |  |                                                                      |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                              |  |                                                                                         |  | 5/18/54                                                                               |  |                                                                      |  |
| 9. AGE (In years last birthday)                                                                                                                                                                                                                                                                                 |  |                                                                                         |  | 18                                                                                    |  |                                                                      |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                      |  |                                                                                         |  | 11. BIRTHPLACE (State or foreign country)                                             |  |                                                                      |  |
| Student                                                                                                                                                                                                                                                                                                         |  |                                                                                         |  | Maryland                                                                              |  |                                                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                    |  |                                                                                         |  | USA.                                                                                  |  |                                                                      |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                               |  |                                                                                         |  | 14. MOTHER'S MAIDEN NAME                                                              |  |                                                                      |  |
| Jerry Morgan                                                                                                                                                                                                                                                                                                    |  |                                                                                         |  | Glendora F. Dean                                                                      |  |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                        |  |                                                                                         |  | 16. SOCIAL SECURITY NO.                                                               |  |                                                                      |  |
| No                                                                                                                                                                                                                                                                                                              |  |                                                                                         |  | 235 44 9486                                                                           |  |                                                                      |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                   |  |                                                                                         |  | ADDRESS                                                                               |  |                                                                      |  |
| Mr. Jerry N. Morgan, Rt. 10 Box 320B                                                                                                                                                                                                                                                                            |  |                                                                                         |  | 21224                                                                                 |  |                                                                      |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                              |  |                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |                                                                      |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                  |  |                                                                                         |  | 5 min                                                                                 |  |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                    |  |                                                                                         |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                               |  |                                                                                         |  | Vomiting, with Aspiration                                                             |  |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                       |  |                                                                                         |  | (B) epileptic seizure                                                                 |  |                                                                      |  |
| (C)                                                                                                                                                                                                                                                                                                             |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| II                                                                                                                                                                                                                                                                                                              |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                        |  | 20A. AUTOPSY? (Yes or No)                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 20                                                                                                                                                                                                                                                                                                              |  |                                                                                         |  | Yes (pending)                                                                         |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |  | 21C. WHERE DID INJURY OCCUR?                                                          |  | (If in Baltimore City, give exact location)                          |  |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                                         |  | Baltimore City Hosp                                                                   |  |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                   |  | 21E. INJURY OCCURRED                                                                    |  | 21F. HOW DID INJURY OCCUR?                                                            |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                 |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |  |                                                                                       |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 7:00 pm 9/3/72 to 7:45 pm 9/3/72 that (I) (we) last saw the deceased alive on 9/3/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                         |  |                                                                                       |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                  |  |                                                                                         |  | 23B. DATE SIGNED                                                                      |  |                                                                      |  |
| William L. Aldis                                                                                                                                                                                                                                                                                                |  |                                                                                         |  | 9/3/72                                                                                |  |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                    |  |                                                                                         |  | 23D. ADDRESS                                                                          |  |                                                                      |  |
| William L. Aldis                                                                                                                                                                                                                                                                                                |  |                                                                                         |  | 4940 Eastern Ave., Baltimore, Md. 21224                                               |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                        |  | 24B. DATE                                                                               |  | 24C. NAME of CEMETERY or CREMATORY                                                    |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                          |  | 9-7-72                                                                                  |  | Oak Lawn Cemetery                                                                     |  | Baltimore, Maryland                                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR                                                                  |  | 25C. FUNERAL DIRECTOR                                                                 |  | ADDRESS                                                              |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                                     |  | John G. Duda                                                                            |  | John G. Duda                                                                          |  | 7922 Wise Ave. Dundalk, Md. 21222                                    |  |

9-18-1972 - Correction form from Funeral Director, John J. Duda, Dundalk, Md.  
(7922 Wise Ave.)

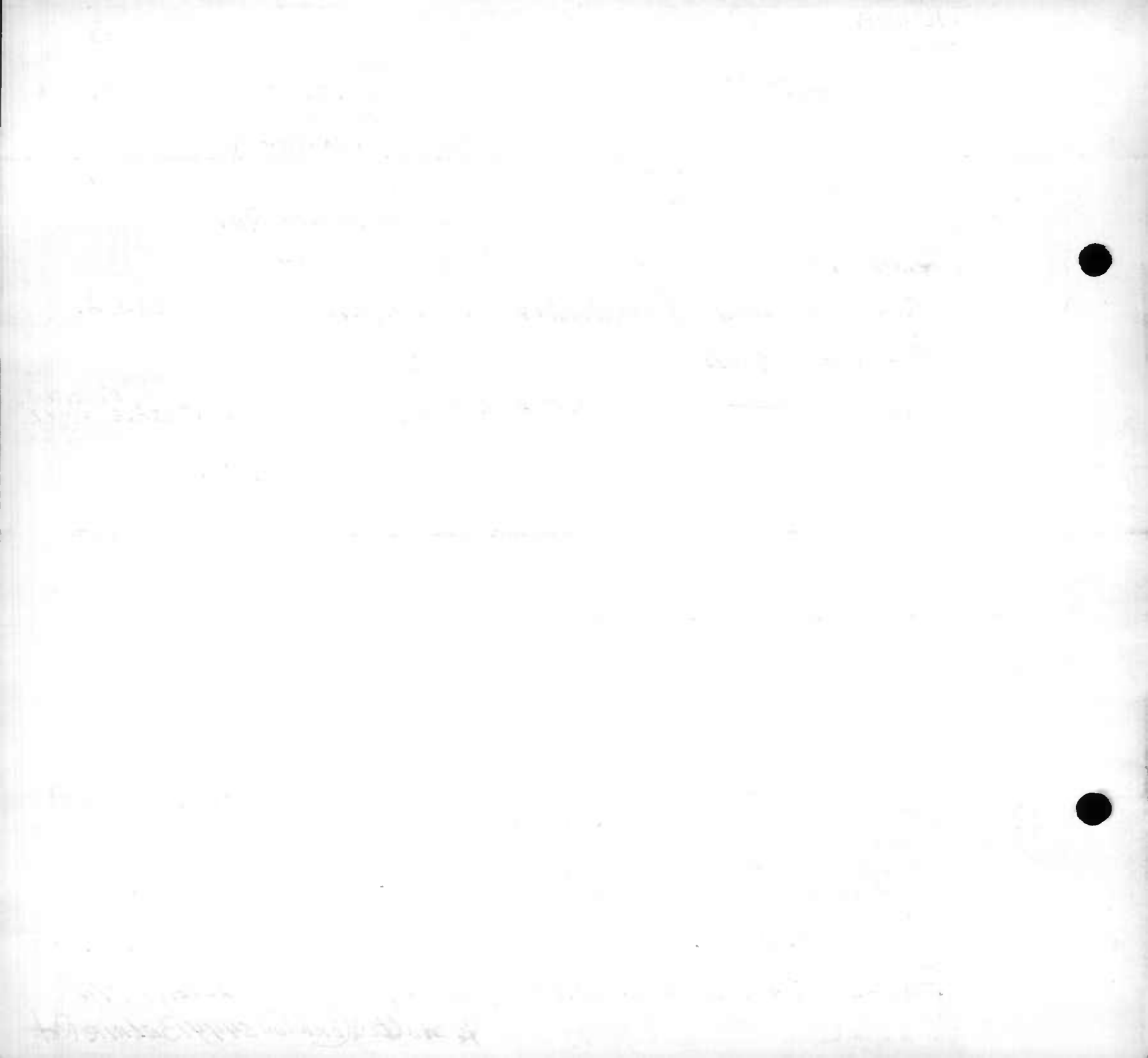
HRS

X

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

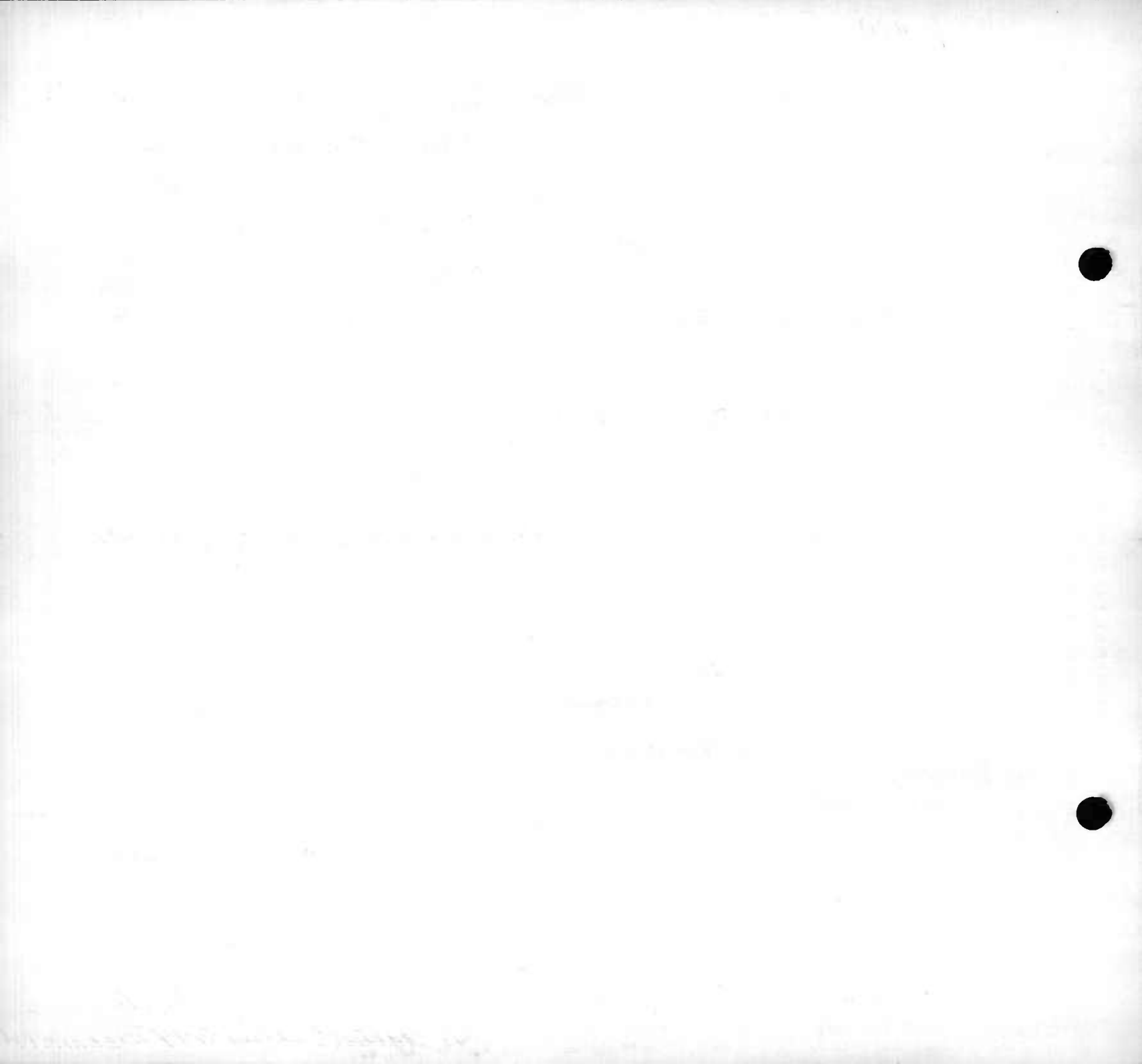
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                                                                                                                                                                                     |                                                                 | REG. NO. <span style="float: right;">72 08655</span>                                 |                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------|
| 1-200 72 08655                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                                                                                                                                                                                     |                                                                 | STATE OF MARYLAND-DHMH                                                               |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print) <u>ELEANORA Margaret Lewis</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 2. DATE AND HOUR OF DEATH<br><u>Sept. 3, 1972</u> <u>6:30 A.M.</u>                                                                                                                                                                                                                                                  |                                                                 |                                                                                      |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>90 Ardleigh Nursing Home</u><br><u>2095 Rockrose Avenue</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>HARFORD</u><br>C. CITY OR TOWN <u>Belair</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <u>211 THOMAS RUN Rd.</u> |                                                                 |                                                                                      |                                                        |
| 5. SEX <u>FEMALE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE <u>WHITE</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                         | 8. DATE OF BIRTH <u>OCTOBER 5, 1887</u>                         | 9. AGE (In years last birthday) <u>84</u>                                            | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKBINDER (RETIRED)</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 10B. KIND OF BUSINESS OR INDUSTRY <u>BOOK BINDING</u>                                                                                                                                                                                                                                                               |                                                                 | 11. BIRTHPLACE (State or foreign country) <u>BALTA, MD.</u>                          |                                                        |
| 13. FATHER'S NAME <u>GEORGE L. KNEEL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 14. MOTHER'S MAIDEN NAME <u>SOPHIA WEIS</u>                                                                                                                                                                                                                                                                         |                                                                 |                                                                                      |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 16. SOCIAL SECURITY NO. <u>213-26-5440</u>                                                                                                                                                                                                                                                                          |                                                                 | 17. INFORMANT <u>MR. ELMERT L. LEWIS</u> ADDRESS <u>FALBTON 915 WATERS AVE 21047</u> |                                                        |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Arteriosclerotic Vas. Dis.</u><br><u>Cerebral Insufficiency</u><br><u>Chronic Brain Syndrome</u><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR |                         |                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                      |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from <u>August 17, 1972</u> to <u>Sept. 3, 1972</u> that (I) (we) last saw the deceased alive on <u>Sept. 3, 1972</u> and that (in my) (our) aptnian death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                      |                                                        |
| 23A. SIGNATURE <u>Lloyd E. Saylor, M.D.</u> DEGREE <u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                                                                                                                                                                                     |                                                                 | 23B. DATE SIGNED <u>Sept. 3, 1972</u>                                                |                                                        |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Lloyd E. Saylor</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 23D. ADDRESS <u>3902 Greenmount Avenue Baltimore, Md. 21218</u>                                                                                                                                                                                                                                                     |                                                                 |                                                                                      |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 24B. DATE <u>9-6-72</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>                                                                                                                                                                                                                                                        | 24D. LOCATION (City, town, or county) (State) <u>BALTA, MD.</u> |                                                                                      |                                                        |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 25B. NAME OF REGISTRAR <u>Lloyd E. Saylor</u>                                                                                                                                                                                                                                                                       |                                                                 | 25C. FUNERAL DIRECTOR <u>J. Walter Conklin</u> ADDRESS <u>5444 BELAIR Rd.</u>        |                                                        |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-420                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 72 08656                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                 |                                                   | 72 08656                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |  | REG. NO.                                                                                                                                                                                                                                                         |                                                   |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Pleiss William Henry, Jr.</u>                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><u>9-2-72</u> <u>3:00 A.M.</u>                                                                                                                                                                                                      |                                                   |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><u>North Charles General Hospital</u>                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>#21206</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                   |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>North Charles General Hospital</u>                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  | E. STREET AND NUMBER<br><u>5913 Grace Ave.</u>                                                                                                                                                                                                                   |                                                   |                                                                      |  |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>6/9/17</u>                                                                                                                                                                                                                                | 9. AGE (in years last birthday)<br><u>55 YRS.</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.            |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ENGINEER</u>                                                                                                                                                                                                                                                                                                     |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Swift and Co.</u>                                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>                                                                                                                                                                                                     |                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                           |  |
| 13. FATHER'S NAME<br><u>William Pleiss Sr.</u>                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><u>Hanna Jamison</u>                                                                                                                                                                                                                 |                                                   |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>4-2-42 to 11-28-45</u>                                                                                                                                                                                                                                                                   |                         | 16. SOCIAL SECURITY NO.<br><u>216-09-1779</u>                                                                                                               |  | 17. INFORMANT<br><u>North Charles General Hospital Chart</u>                                                                                                                                                                                                     |                                                   |                                                                      |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Severe Cachexia</u><br><u>Metastatic Ca of Stomach</u> |                         |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                     |                                                   |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                  |                                                   |                                                                      |  |
| 19A. DATE OF OPERATION<br><u>9-2-72</u>                                                                                                                                                                                                                                                                                                                                                                            |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                        |                                                   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                         |                                                   |                                                                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                          |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                       |                                                   |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-14</u> 19 <u>72</u> to <u>9-2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-2</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>3:00 AM 9-2-72</u>                                          |                         |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                  |                                                   |                                                                      |  |
| 23A. SIGNATURE<br><u>Eduardo C. Yater, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                                                                  |                                                   | 23B. DATE SIGNED<br><u>9-2-72</u>                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>EDUARDO C. YATCO, M.D.</u>                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |  | 23D. ADDRESS<br><u>NORTH CHARLES GEN. HOSP.</u>                                                                                                                                                                                                                  |                                                   |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                          |                         | 24B. DATE<br><u>9-5-72</u>                                                                                                                                  |  | 24C. NAME of CEMETERY or CREMATORY<br><u>LEARNINE PARK</u>                                                                                                                                                                                                       |                                                   | 24D. LOCATION (City, town, or county) (State)<br><u>BALTO., Md.</u>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                                                                                              |                         | 25B. NAME OF REGISTRAR<br><u>Indy...</u>                                                                                                                    |  | 25C. FUNERAL DIRECTOR<br><u>Indy...</u> ADDRESS<br><u>5444 BELAIR RD</u>                                                                                                                                                                                         |                                                   |                                                                      |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | REG. NO. 72 08657                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| L-150                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 72 08657                                                                                 |  | STATE OF MARYLAND-DEME                                                                |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 1. NAME OF DECEASED<br>(Type or Print)                                                   |  | 2. DATE AND HOUR OF DEATH                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | LAVIN, JOSEPH WILLIAM                                                                    |  | SEPTEMBER 4, 1972 8:00P M.                                                            |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |  |                                                                                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                              |  | A. STATE B. COUNTY                                                                       |  |                                                                                       |  |
| ST AGNES HOSPITAL<br>WILKENS & CATON AVES<br>BALTIMORE, MD. 21229                                                                                                                                                                                                                                                                                                                                                                                                                         |  | MD. BALTIMORE                                                                            |  |                                                                                       |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6. RACE                                                                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | White                                                                                    |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                               |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 8. DATE OF BIRTH                                                                      |  |
| TRUCK DRIVER                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | M&T CHEMICAL CO.                                                                         |  | 09 26 12                                                                              |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. MOTHER'S MAIDEN NAME                                                                 |  | 9. AGE (In years last birthday)                                                       |  |
| F. JOHN LAVIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | ROSE POWERS                                                                              |  | 59                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                  |  | 16. SOCIAL SECURITY NO.                                                                  |  | 17. INFORMANT                                                                         |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 219-01-8336                                                                              |  | Mrs. Rita A. Lavin, 1200 Robin Court                                                  |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?                                                             |  | ADDRESS                                                                               |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | U.S.A.                                                                                   |  | 21227 STAGNES RECORDS WILKENS & CATON AVES.                                           |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                             |  |                                                                                       |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  |                                                                                       |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                              |  | Pulmonary edema                                                                          |  |                                                                                       |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  |                                                                                       |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                                                                                                                 |  | Metastatic Ca of Lung.                                                                   |  |                                                                                       |  |
| II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  |                                                                                       |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                          |  | To the heart & mediastinum                                                               |  |                                                                                       |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                             |  |
| 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                          |  | YES                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                            |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                       |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 1, 19 72 to SEPTEMBER 4, 19 72. that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPTEMBER 4, 19 72 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. |  |                                                                                          |  |                                                                                       |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                          |  | 23B. DATE SIGNED                                                                      |  |
| EITATSU HENZAN M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                          |  | 9/5/72                                                                                |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                          |  | 23D. ADDRESS                                                                          |  |
| CATON & WILKENS AVENUE 21229                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                          |  |                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY                                                    |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 9-8-1972                                                                                 |  | Meadowridge Cemetery                                                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                 |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | Didney Whitson                                                                           |  | Howard H. Hubbard, 4107 Wilkens Ave. 21229                                            |  |

LAVIN, JOSEPH WILLIAM

SEPTEMBER 4, 1973

BALTIMORE

ST AGNES HOSPITAL  
WILKINS & CATON AVES  
BALTIMORE, MD. 21229  
XX

1200 ROBIN COURT

09 26 12

TRUCK DRIVER

WEST CHEMICAL CO. MARYLAND

ROSE POWERS

JOHN LAVIN

STAGNES RECORDS

WILKINS & CATON AVES

YES

XX

X

SEPTEMBER 4, 1973

XX

XXX

SEPTEMBER 4, 1973

WILKINS & CATON AVES

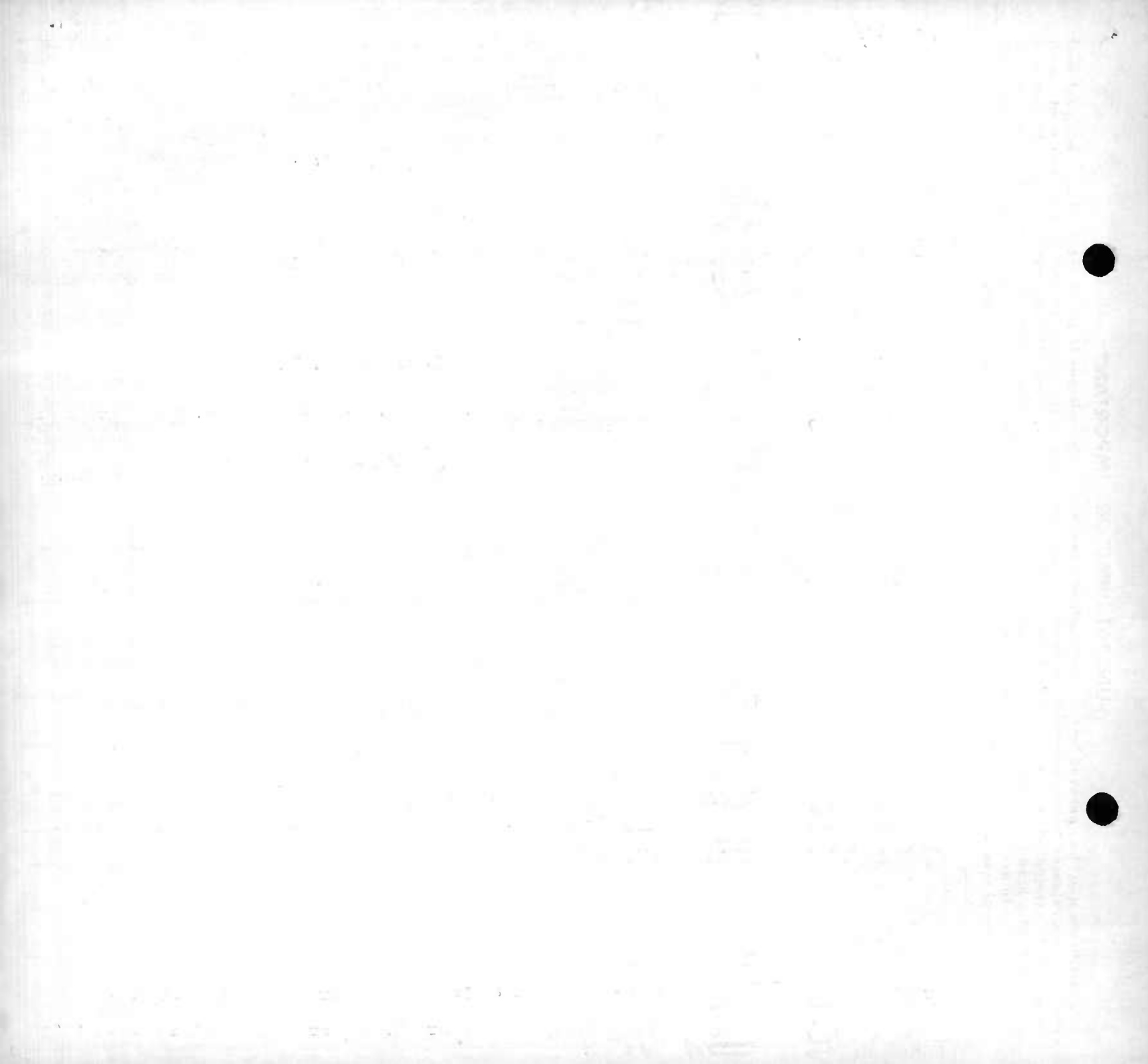
WILKINS & CATON AVES



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                         | REG. NO. 72-88658                                                                                                                                                 |                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                   |                                                                                                   |
| BIRTH NO. <u>M-324</u><br><u>90-1765072 08658</u>                                                                                                                                                                                                                                                                                                    |                      | 1. NAME OF DECEASED<br>(Type or Print) <u>Mitchell, Karen</u>                                                                                               |                                                                                                                                                                                                                                                                                                                                         | 2. DATE AND HOUR OF DEATH<br><u>9-5-72</u> <u>8:45 A</u> M.                                                                                                       |                                                                                                   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Sinai Hospital of Baltimore</u>                                                                                                                                        |                      |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u><br>C. CITY OR TOWN <u>Highlands</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>125 S. Twin Circle Way 21227</u> |                                                                                                                                                                   |                                                                                                   |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                      | 6. RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-4-70</u>                                                                                                                                                                                                                                                                                                         | 9. AGE (in years last birthday) <u>1</u> <u>2</u>                                                                                                                 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                          |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                                                                                                                                                                                                         | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                                                                                                         |                                                                                                   |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                                                                                                                                                                                                                                              |                      | 13. FATHER'S NAME <u>E. John Mitchell</u>                                                                                                                   |                                                                                                                                                                                                                                                                                                                                         | 14. MOTHER'S MAIDEN NAME <u>Patricia M. English</u>                                                                                                               |                                                                                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>                                                                                                                                                                                                                                   |                      | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                         | 17. INFORMANT ADDRESS <u>21227</u><br><u>Mr. John E. Mitchell, 125 S. Twin Circle Way</u>                                                                         |                                                                                                   |
| 18. <u>74691</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Pulmonary Edema</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>Congenital Heart Disease</u>                                                                                                                                  |                                                                                                                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>15 min.</u><br><u>15 min.</u><br><u>2 yrs.</u> |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                     |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                   |                                                                                                   |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                               |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                         | 20A. AUTOPSY? (Yes or No)                                                                                                                                         |                                                                                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                          |                                                                                                   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                            |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                         | 21F. HOW DID INJURY OCCUR?                                                                                                                                        |                                                                                                   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-1-72</u> 19 to <u>9-5-72</u> 19<br>that (I) (we) lost saw the deceased alive on <u>9-5-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.              |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                   |                                                                                                   |
| 23A. SIGNATURE <u>Edward L. Schore</u><br>DEGREE                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                         | 23B. DATE SIGNED <u>9-5-72</u><br>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                                                                                   |
| 23C. PHYSICIAN'S NAME (Type) <u>Edward L. Schore</u><br>DEGREE                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                         | 23D. ADDRESS <u>Sinai Hospital</u>                                                                                                                                |                                                                                                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                               |                      | 24B. DATE <u>9-8-1972</u>                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                         | 24C. NAME of CEMETERY or CREMATORY <u>Lake View Memorial Park</u>                                                                                                 |                                                                                                   |
| 24D. LOCATION (City, town, or county) (State) <u>Carroll County, Maryland</u>                                                                                                                                                                                                                                                                        |                      | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 11 1972</u>                                                                                                          |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                   |                                                                                                   |
| 25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>                                                                                                                                                                                                                                                                                                      |                      | 25C. FUNERAL DIRECTOR ADDRESS <u>4107 Wilkens Ave. 21229</u>                                                                                                |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                   |                                                                                                   |



| STATE OF MARYLAND - DEPT. OF HEALTH                                                                                                                                                                                                                                                                                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| M-253                                                                                                                                                                                                                                                                                                                                                                                                         |  | 72 08659                                                                                                   |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO. 72 08659                                                                                          |  |
| 1. NAME OF DECEASED<br>(Type or Print) M. SIDNEY McINTIRE, SR.                                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>40 ST. AGNES HOSPITAL                                                                                                                                                                                                                  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>September 5, 1972 3:53 P. M.                             |  |
| 6. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7. RACE White                                                                                              |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                         |  | 9. DATE OF BIRTH<br>11-9-1904                                                                              |  |
| 10. AGE (In years last birthday) 67                                                                                                                                                                                                                                                                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                        |  | 13. FATHER'S NAME<br>Charles E. McIntire                                                                   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Armature Winder Bethlehem Steel Co.                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>Anna May Norris                                                                |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                 |  | 17. SOCIAL SECURITY NO.<br>213-07-0990A                                                                    |  |
| 18. INFORMANT<br>Mrs. Mildred A. Mitchell                                                                                                                                                                                                                                                                                                                                                                     |  | ADDRESS<br>21227 1712 Wilson Ave.                                                                          |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease                                                                                                                                                                   |  | CAUSE OF DEATH<br>Arteriosclerotic cardiovascular disease                                                  |  |
| 20. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                         |  | 21. AUTOPSY? (Yes or No)<br>no                                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |  | 22D. TIME OF INJURY (APPROX.)                                                                              |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  | 22F. HOW DID INJURY OCCUR?                                                                                 |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 24. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                          |  |
| 24B. DATE<br>9-8-1972                                                                                                                                                                                                                                                                                                                                                                                         |  | 24C. NAME of CEMETERY or CREMATORY<br>Meadowridge Cemetery                                                 |  |
| 24D. LOCATION (City, town, or county) (State)<br>Wash. Blvd. Howard Co., Md.                                                                                                                                                                                                                                                                                                                                  |  | 24E. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br>Sidney P. Mulloy                                                                 |  |
| 25C. NAME OF CEMETERY or CREMATORY<br>Meadowridge Cemetery                                                                                                                                                                                                                                                                                                                                                    |  | 25D. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229                                        |  |



1

72 08660

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 72 08660

REG. NO. 72 08660

1. NAME OF DECEASED (Type or Print) HOWARD JONES

2. DATE OF DEATH Known ☐ Month Day Year Hour Estimated ☐ M.

3. DATE PRONOUNCED DEAD September 5, 1972 7:10 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET HOSPITAL OR INSTITUTION) ST. AGNES HOSPITAL

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY Baltimore

6. SEX Male 7. RACE White 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES ☐ NO ☒

9. DATE OF BIRTH 10-8-1972 10. AGE (In years last birthday) 63 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. E. STREET AND NUMBER 903 Rambling Drive

11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Frederick Jones

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 14B. KIND OF BUSINESS OR INDUSTRY retired 15. MOTHER'S MAIDEN NAME Elsie Darsch

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 17. SOCIAL SECURITY NO. 212-03-6764 18. INFORMANT ADDRESS Mrs. Elinore Jones, 903 Rambling Dr.

19. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
Ruptured aneurysm of aorta  
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  
(B) DUE TO, OR AS A CONSEQUENCE OF:  
(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 9-8-1972 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED yes 21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR? 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 22E. INJURY OCCURRED 22F. HOW DID INJURY OCCUR?  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE Peter Lipkovic M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 9/6/72  
EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9-8-1972 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State) Wilkins Ave. Balto. Md.

25A. DATE REC'D BY HEALTH DEPT. SEP 11 1972 25B. NAME OF REGISTRAR Sidney H. Heston 25C. FUNERAL DIRECTOR ADDRESS Hubbard Funeral Home Inc. 4107 Wilkins

9-19-1972 - Correction Form from Funeral Director-Hubbard Funeral Home Inc., 4107 Wilkens Ave.,  
Balto., Md. HRS

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Ronald Waddell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 9 4 72<br>2:00A. M.       |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>9 4 72<br>2:00 A. M.                                                                            |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. RACE<br><b>Negro</b>                                                                                                                      |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                          |  |
| 9. DATE OF BIRTH<br><b>2/25/54</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10. AGE (in years lost birthday)<br><b>18</b>                                                                                                |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Wash., DC.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |  |
| 13. FATHER'S NAME<br><b>Thomas Riley</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>BALTO</b> |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Lorraine Price</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                      |  |
| 17. SOCIAL SECURITY NO.<br><b>215 66 7606</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 18. INFORMANT<br><b>Mrs. Lorraine Riley-8211 Sherrill</b>                                                                                    |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                 |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |  |
| 21. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>                                    |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Barlowe Rd and 82</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>9 1 72 9:50P.</b>                                                            |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22F. HOW DID INJURY OCCUR?<br><b>Pedestrian struck by car</b>                                                                                |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-7-72</b> |  |                                                                                                                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 24B. DATE<br><b>9/9/72</b>                                                                                                                   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Harmony Memorial Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 24D. LOCATION (City, town, or county) (State)<br><b>Maryland</b>                                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR<br><b>Frederick J. Stewart</b>                                                                                        |  |
| 25C. FUNERAL DIRECTOR<br><b>Stewart Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS<br><b>4001 Benning Rd N.E.</b>                                                                                                       |  |



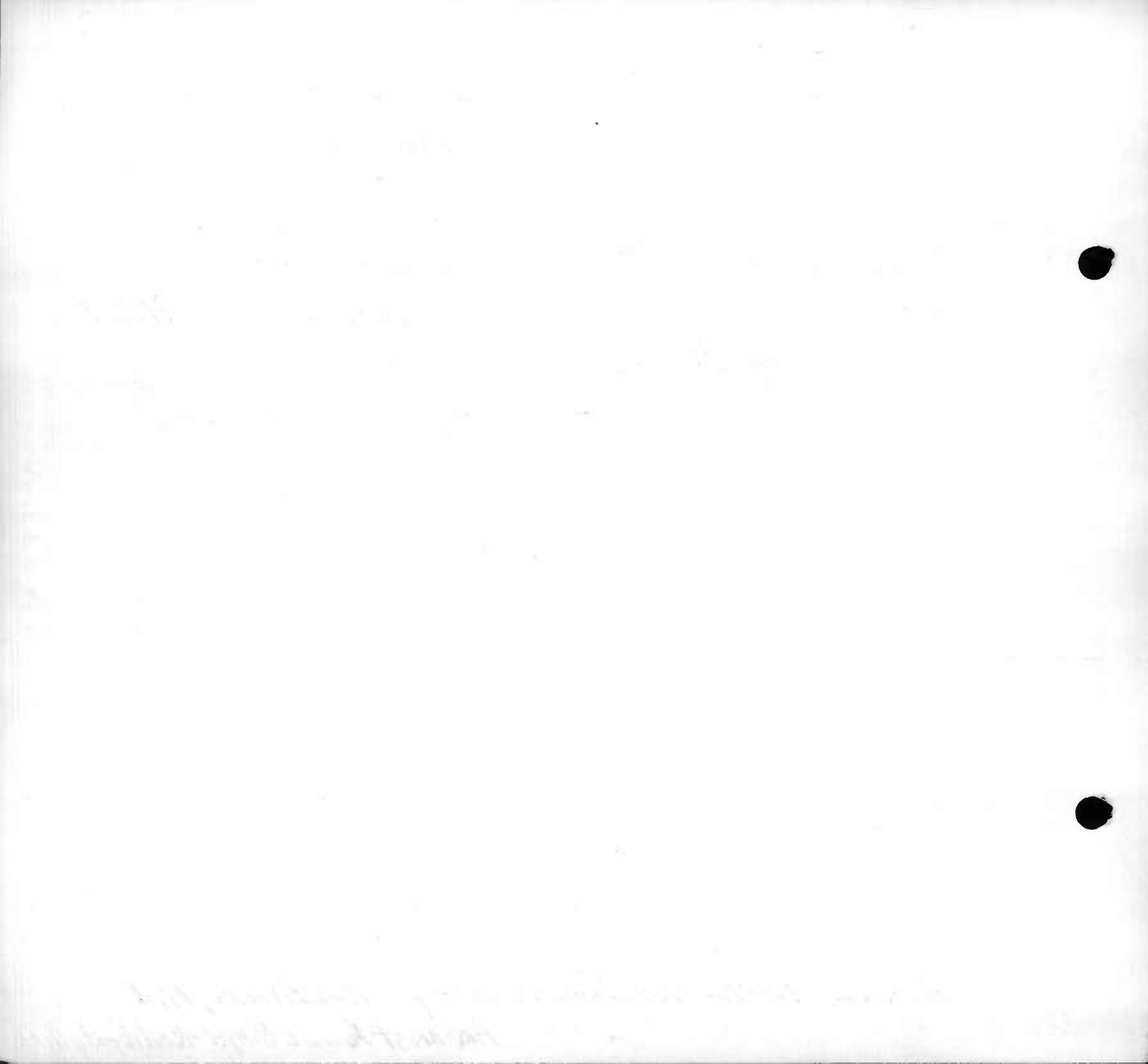
1501-1543



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  |                                                                                                                                         |  |                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| S-420                                                                                                                                                                                                                                                                                                                                                                                         |  | 72 08662                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                        |  | 72 08662                                                              |  |
| <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | REG. NO. _____                                                                                                                          |  |                                                                       |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>CAROLINE I. So Leas</i>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><i>Sept 5, 1972 8:55 P.</i>                                                                                |  |                                                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>House In The Pines - Belvedere</i>                                                                                                                                                                              |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>2802</i> |  |                                                                       |  |
| 5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                            |  |                                                                                                           |  | 8. DATE OF BIRTH<br><i>3-3-1897</i>                                                                                                     |  | 9. AGE (in years last birthday) <i>75</i>                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>At Home</i>                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                       |  | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore</i>         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 13. FATHER'S NAME<br><i>Henry Meeks</i>                                                                                                 |  |                                                                       |  |
| 14. MOTHER'S MAIDEN NAME<br><i>MARY Korber</i>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>-</i>                    |  |                                                                       |  |
| 16. SOCIAL SECURITY NO.<br><i>-</i>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  | 17. INFORMANT<br><i>GARY L So Leas - Same</i>                                                                                           |  |                                                                       |  |
| 18. <i>412.31</i> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                      |  |                                                                                                           |  | A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>1) Arterio Sclerotic Heart Disease</i>                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 yrs.</i>         |  |
|                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  | B) <i>2. Broncho Pneumonia</i>                                                                                                          |  | <i>5 days</i>                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  | C) <i>Cerebral Vascular Stroke</i>                                                                                                      |  | <i>2 yrs.</i>                                                         |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><i>Arterio Sclerosis (General)</i>                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                         |  |                                                                       |  |
| 19A. DATE OF OPERATION<br><i>None</i>                                                                                                                                                                                                                                                                                                                                                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                                                                                  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                |  |                                                                       |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                              |  |                                                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/17</i> 19 <i>67</i> to <i>9/5</i> 19 <i>72</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>9/5/72</i> - 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) did not view the body after death. |  |                                                                                                           |  |                                                                                                                                         |  |                                                                       |  |
| 23A. SIGNATURE<br><i>Earl L. Chambers M.D.</i>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 23B. DATE SIGNED<br><i>9/6/72</i>                                                                                                       |  |                                                                       |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Earl L. Chambers - M.D.</i>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 23D. ADDRESS<br><i>100-W. Cold Spring Balto - Md</i>                                                                                    |  |                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><i>9-8-72</i>                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Cemetery</i>                                                                          |  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 11 1972</i>                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><i>William Wharton</i>                                                          |  | 25C. FUNERAL DIRECTOR<br><i>Harmon St. Renewal Chapel 4601 Liberty Hts</i>                                                              |  | ADDRESS                                                               |  |



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1900

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| BIRTH NO. <b>S-316</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                                                                | REG. NO. <b>72 08663</b>                                                                      |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                                                                                | STATE OF MARYLAND - <del>DEMD</del>                                                           |
| <b>STAUFFER, EDNA ELIZABETH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | <b>SEPTEMBER 8, 1972</b>                                                                                                                                    |                                                                                | <b>6:50 A.M.</b>                                                                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)                                                                       |                                                                                |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | A. STATE<br><b>MARYLAND</b>                                                                                                                                 |                                                                                | B. COUNTY<br><b>BALTIMORE</b>                                                                 |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>CATON &amp; WILKENS AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                         |                                                                                | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| <b>BALTIMORE, MARYLAND 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | E. STREET AND NUMBER<br><b>2236 SOUTHLAND ROAD</b>                                                                                                          |                                                                                | <b>5300</b>                                                                                   |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><b>CAUCASIAN</b>                                                                               | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>07/25/11</b>                                            | 9. AGE (In years last birthday)<br><b>61</b>                                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BOOKKEEPER</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>                                                                                                         |                                                                                | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | 13. FATHER'S NAME<br><b>LOUIS ROMM</b>                                                                                                                      |                                                                                | 14. MOTHER'S MAIDEN NAME<br><b>CLARA BLOTKAMP</b>                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>213-05-0917</b>                                                                                                               |                                                                                | 17. INFORMANT<br><b>BALTO MD 21229</b>                                                        |
| 18. <b>203501</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | CAUSE OF DEATH                                                                                                                                              |                                                                                | ADDRESS<br><b>ST AGNES' RECORDS CATON &amp; WILKENS AVE</b>                                   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                           |                                                                                                           | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Acute myelomonocytic Leukemia</b>                                                              |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Pulmonary infection</b>                                                                                           |                                                                                |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                               |
| 19A. DATE OF OPERATION<br><b>21</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |                                                                                |                                                                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |                                                                                |                                                                                               |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JULY 21</b> 19 <b>72</b> to <b>SEPTEMBER 8</b> 19 <b>72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 8</b> 19 <b>72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (XXX) view the body after death. |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                               |
| 23A. SIGNATURE<br><b>Eitatsu Henzan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 23B. DATE SIGNED<br><b>9/8/72</b>                                                                                                                           |                                                                                |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><b>EITATSU HENZAN M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 23D. ADDRESS<br><b>AVES BALTO, MD 21229</b><br><b>ST. AGNES HOSPITAL; CATON &amp; WILKENS</b>                                                               |                                                                                |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 24B. DATE<br><b>9/11/72</b>                                                                               | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                                                                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn Baltimore Md.</b> |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 25B. NAME OF REGISTRAR<br><b>Stansbury Funeral Home</b>                                                   | 25C. FUNERAL DIRECTOR<br><b>4659</b>                                                                                                                        | ADDRESS<br><b>6411 Windsor Mill</b>                                            |                                                                                               |

STANLEY, EDNA ELIZABETH  
BIRTH: 1902  
DEATH: 1972

BALTIMORE, MARYLAND

AT AGNES HOSPITAL  
CITY & WILKINSON AVENUE  
BALTIMORE, MARYLAND 21205

WHITE CAUCASIAN  
SEX: F  
AGE: 70

BOOKED FOR  
BALTIMORE, MARYLAND

CLARA BUCHANAN  
BALTIMORE, MARYLAND

212-11-0017 ST AGNES HOSPITAL  
CITY & WILKINSON AVENUE

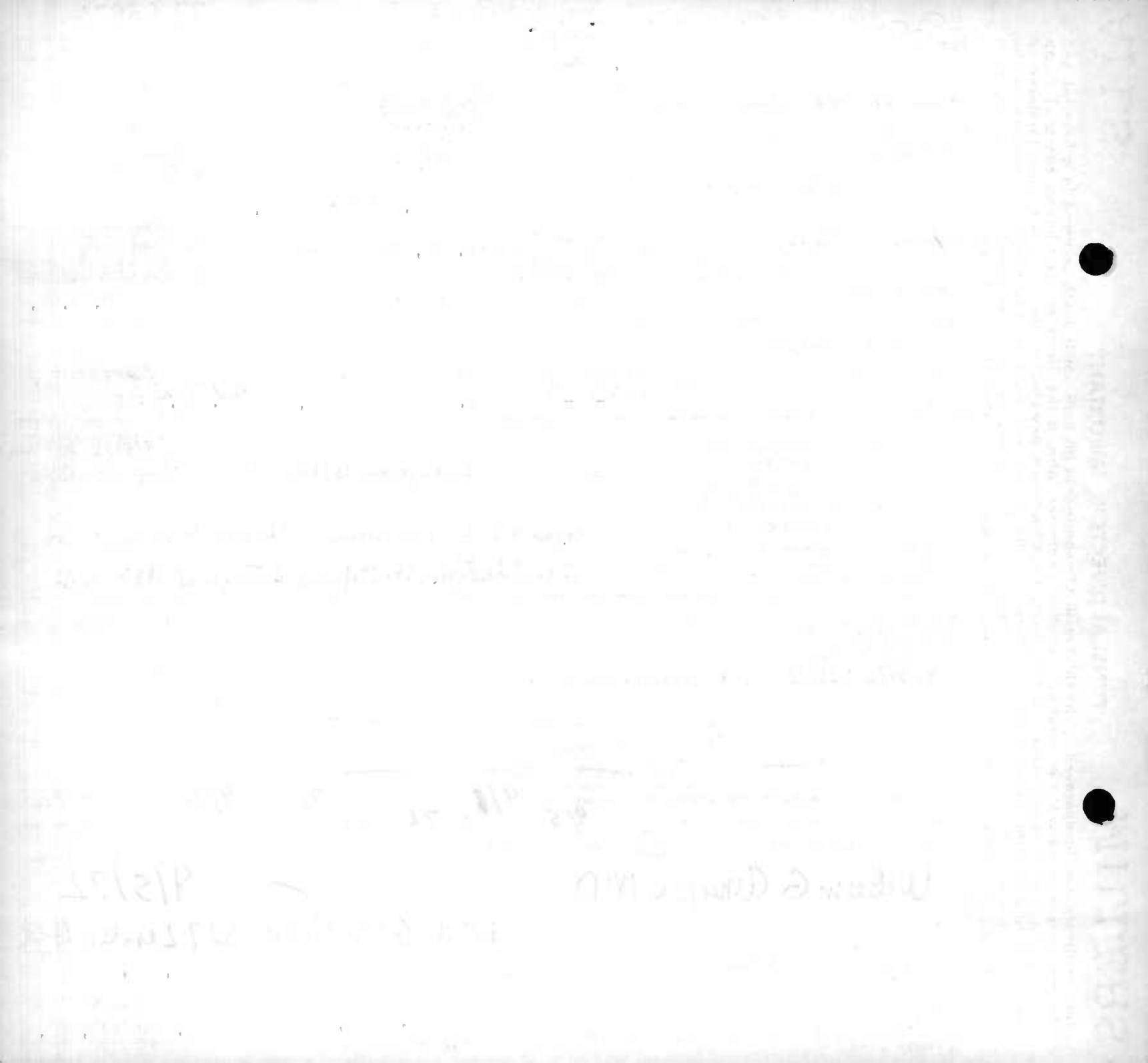
SEPTEMBER 9 1972  
JULY 27 1972  
BALTIMORE, MARYLAND

ST. AGNES HOSPITAL  
CITY & WILKINSON AVENUE  
BALTIMORE, MARYLAND 21205

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                          |  | BALTIMORE CITY HEALTH DEPARTMENT                                                             |  | 72 08664                                                                              |  | REG. NO.                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                             |  | Emma A. Sohn                                                                                 |  | 2. DATE AND HOUR OF DEATH                                                             |  | 9-5-72 3:43 AM 9-5-72 V M.                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                             |  |                                                                                              |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                               |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                         |  | A. STATE                                                                              |  | B. COUNTY                                                            |  |
| 48 Maryland General Hospital                                                                                                                                                                                                                                                                       |  |                                                                                              |  | Maryland                                                                              |  | 2610                                                                 |  |
| 5. SEX                                                                                                                                                                                                                                                                                             |  | 6. RACE                                                                                      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>            |  | 8. DATE OF BIRTH                                                     |  |
| Female                                                                                                                                                                                                                                                                                             |  | White                                                                                        |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | Jan. 20, 1898                                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                            |  | 9. AGE (In years lost birthday)                                                       |  | 11. BIRTHPLACE (State or foreign country)                            |  |
| Housewife                                                                                                                                                                                                                                                                                          |  |                                                                                              |  | 74                                                                                    |  | Maryland                                                             |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                  |  | 14. MOTHER'S MAIDEN NAME                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?                                                          |  | U. S. A.                                                             |  |
| Stephen Knight                                                                                                                                                                                                                                                                                     |  | Mary Schrodt                                                                                 |  | 17. INFORMANT (Nephew) 533 Hampton LADRESS                                            |  | Mr. Robert Knight, Balto. Md. 21204                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO.                                                                      |  | 17. INFORMANT (Nephew) 533 Hampton LADRESS                                            |  | Mr. Robert Knight, Balto. Md. 21204                                  |  |
| No                                                                                                                                                                                                                                                                                                 |  | 212-74-7106                                                                                  |  |                                                                                       |  |                                                                      |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                 |  |                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                         |  |                                                                                              |  | 9/5/72 2:43 AM                                                                        |  |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                  |  |                                                                                              |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                          |  |                                                                                              |  | Pneumonia, GI bleed -> Cardiac respiratory arrest                                     |  |                                                                      |  |
| II                                                                                                                                                                                                                                                                                                 |  |                                                                                              |  | (B) Cause x3 wk: pneumonia, GI bleed, urinary bleed.                                  |  |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                   |  |                                                                                              |  | (C) GI bleed, leukemia multifactorial (2) temporal dx 8/12/72                         |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                             |  | 20A. AUTOPSY? (Yes or No)                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 8/18/72, 8/22/72                                                                                                                                                                                                                                                                                   |  | p & serious condition                                                                        |  | No                                                                                    |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)      |  | 21C. WHERE DID INJURY OCCUR?                                                          |  | (If in Baltimore City, give exact location)                          |  |
| No                                                                                                                                                                                                                                                                                                 |  |                                                                                              |  |                                                                                       |  |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                      |  | 21E. INJURY OCCURRED                                                                         |  | 21F. HOW DID INJURY OCCUR?                                                            |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                    |  | While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> |  |                                                                                       |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/1/72 to 9/5/72 and that (I) (we) lost saw the deceased alive on 9/5/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. |  |                                                                                              |  |                                                                                       |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                     |  |                                                                                              |  | 23B. DATE SIGNED                                                                      |  |                                                                      |  |
| William G. Meyer MD                                                                                                                                                                                                                                                                                |  |                                                                                              |  | 9/5/72                                                                                |  |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                       |  |                                                                                              |  | 23D. ADDRESS                                                                          |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                    |  |                                                                                              |  | Mid. Gen Hosp, 827 Linden Ave                                                         |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                           |  | 24B. DATE                                                                                    |  | 24C. NAME of CEMETERY or CREMATORY                                                    |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                             |  | 9/9/72                                                                                       |  | Woodlawn Cemetery                                                                     |  | Woodlawn, Md.                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR                                                                       |  | 25C. FUNERAL DIRECTOR                                                                 |  | ADDRESS                                                              |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                        |  | John J. Duda                                                                                 |  | 7922 Wise Ave. Dundalk, Md.                                                           |  |                                                                      |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Y-520                                                                                                                                                                                                                                                                                                                       |  | 72 08665                                                                                               |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                |  | REG. NO. 72 08665                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | STATE OF MARYLAND-DEATH                                                                                                         |  |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 2. DATE AND HOUR OF DEATH                                                                                                       |  |                                                                      |  |
| MAY ELIZABETH YOUNG                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | September 6, 1972 1:45 P.M.                                                                                                     |  |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                           |  |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                |  |                                                                                                        |  | A. STATE B. COUNTY                                                                                                              |  |                                                                      |  |
| The Wesley Home Inc<br>2211 West Rogers Avenue                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | Maryland                                                                                                                        |  |                                                                      |  |
| 90                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | C. CITY OR TOWN D. INSIDE CITY LIMITS?                                                                                          |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                   |  |                                                                      |  |
| E. STREET AND NUMBER                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | 2211 West Rogers Avenue                                                                                                         |  |                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                      |  | 6. RACE                                                                                                |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                      |  | 8. DATE OF BIRTH                                                     |  |
| Female                                                                                                                                                                                                                                                                                                                      |  | White                                                                                                  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                   |  | May 6 1883                                                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                 |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                      |  | 9. AGE (In years last birthday)                                                                                                 |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.            |  |
| Housewife                                                                                                                                                                                                                                                                                                                   |  | -                                                                                                      |  | 89                                                                                                                              |  |                                                                      |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                    |  |                                                                      |  |
| Maryland                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | USA                                                                                                                             |  |                                                                      |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 14. MOTHER'S MAIDEN NAME                                                                                                        |  |                                                                      |  |
| Jarvis Dickinson                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | Margaret V. Smith                                                                                                               |  |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO.                                                                                |  | 17. INFORMANT ADDRESS                                                                                                           |  |                                                                      |  |
| No                                                                                                                                                                                                                                                                                                                          |  | 218 52 2466                                                                                            |  | The Wesley Home Inc same                                                                                                        |  |                                                                      |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| II                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No)                                                                                                       |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | No                                                                                                                              |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                        |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                   |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                      |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 31 October 1971 to 6 September 1972, that (I) (we) lost saw the deceased alive on 31 August 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                 |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED                                                     |  |
| John W. Barnaby                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | DEGREE                                                                                                                          |  | 8 Sept 72                                                            |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | 23D. ADDRESS                                                                                                                    |  |                                                                      |  |
| Dr. John W. Barnaby                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 1652 East Belvedere Avenue                                                                                                      |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                    |  | 24B. DATE                                                                                              |  | 24C. NAME OF CEMETERY or CREMATORY                                                                                              |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                                      |  | 9 Sep 72                                                                                               |  | Still Pond Cemetery                                                                                                             |  | Still Pond, Kent Co, Maryland                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                             |  | 25B. NAME OF REGISTRAR                                                                                 |  | 25C. FUNERAL DIRECTOR                                                                                                           |  | ADDRESS                                                              |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                 |  | Bridget H. Heston                                                                                      |  | Burgess Funeral Home, Baltimore, Maryland                                                                                       |  |                                                                      |  |



8/30/62 -Adm.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                    |                        |                                                                                          |                                               | REG. NO. 72 08666                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------|
| B-652                                                                                                                                                                                                                                                                                               |                        | 72 08666                                                                                 |                                               | 72 08666                                                                 |
| <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                         |                        |                                                                                          |                                               |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                              |                        | 2. DATE AND HOUR OF DEATH                                                                |                                               |                                                                          |
| Georgis Frances Burns                                                                                                                                                                                                                                                                               |                        | Sept. 4, 1972 10:45 P. M.                                                                |                                               |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                              |                        | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)    |                                               |                                                                          |
| 90 Long Green Nursing Home                                                                                                                                                                                                                                                                          |                        | Md. Balto 5300                                                                           |                                               |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                        |                        | C. CITY OR TOWN                                                                          |                                               | D. INSIDE CITY LIMITS?                                                   |
| White Hall                                                                                                                                                                                                                                                                                          |                        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |                                               |                                                                          |
|                                                                                                                                                                                                                                                                                                     |                        | E. STREET AND NUMBER                                                                     |                                               |                                                                          |
|                                                                                                                                                                                                                                                                                                     |                        | Graystone Rd.                                                                            |                                               |                                                                          |
| 5. SEX                                                                                                                                                                                                                                                                                              | 6. RACE                | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>    | 8. DATE OF BIRTH                              | 9. AGE (In years last birthday)                                          |
| F.                                                                                                                                                                                                                                                                                                  | Cauc.                  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | Feb. 15, 1905                                 | 67                                                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                         |                        | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                                               | 11. BIRTHPLACE (State or foreign country)                                |
| Secretary                                                                                                                                                                                                                                                                                           |                        | Insurance                                                                                |                                               | White Hall, Md.                                                          |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                   |                        | 14. MOTHER'S MAIDEN NAME                                                                 |                                               |                                                                          |
| Clarence M. Burns                                                                                                                                                                                                                                                                                   |                        | Ella Mae Almony                                                                          |                                               |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                         |                        | 16. SOCIAL SECURITY NO.                                                                  |                                               | 17. INFORMANT ADDRESS                                                    |
| No                                                                                                                                                                                                                                                                                                  |                        | 212-03-1589                                                                              |                                               | Ruth A. Burns, White Hall, Md. 31161                                     |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                  |                        | CAUSE OF DEATH                                                                           |                                               |                                                                          |
| 412.3 I                                                                                                                                                                                                                                                                                             |                        | Pneumonia, bilat. 4 yrs.                                                                 |                                               |                                                                          |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                        |                        | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                                               |                                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                   |                        | (B) Anteriosclerotic heart disease 2 yrs.                                                |                                               |                                                                          |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                           |                        | (C) Parkinson's disease 4 yrs.                                                           |                                               |                                                                          |
| II                                                                                                                                                                                                                                                                                                  |                        |                                                                                          |                                               |                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                    |                        |                                                                                          |                                               |                                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                              |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                                               | 20A. AUTOPSY? (Yes or No)                                                |
| O                                                                                                                                                                                                                                                                                                   |                        |                                                                                          |                                               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                               |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                       |                        | 21E. INJURY OCCURRED                                                                     |                                               | 21F. HOW DID INJURY OCCUR?                                               |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                         |                        | While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>             |                                               |                                                                          |
| 22. I certify that (I) (the hospital) attended the deceased from 8/29 1972 to Sept 4 1972 that (I) (we) last saw the deceased alive on 8/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |                        |                                                                                          |                                               |                                                                          |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                      |                        | 23B. DATE SIGNED                                                                         |                                               |                                                                          |
| Norman R Freeman                                                                                                                                                                                                                                                                                    |                        | 9/7/72                                                                                   |                                               |                                                                          |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                        |                        | 23D. ADDRESS                                                                             |                                               |                                                                          |
| N R FREEMAN R                                                                                                                                                                                                                                                                                       |                        | 11 W 24th St                                                                             |                                               |                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                            | 24B. DATE              | 24C. NAME OF CEMETERY or CREMATORY                                                       | 24D. LOCATION (City, town, or county) (State) |                                                                          |
| Burial                                                                                                                                                                                                                                                                                              | Sept. 7, 1972          | Wiseburg Cemetery                                                                        | White Hall, Md.                               |                                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                     | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR                                                                    |                                               | ADDRESS                                                                  |
| SEP 11 1972                                                                                                                                                                                                                                                                                         | Aileen J. [unclear]    | James J. Hartenstein                                                                     |                                               | New Freedom, Pa.                                                         |

1000 1000 1000

Mr. Balle

White Hall

Graystone Rd.

\* Feb. 1912

White Hall, Md.

Elia Mae Hixson

Long Green Nursing Home

F. Case

Secretary Insurance

Clarence M. Burns

No

210-03-1589

White Hall, Md.

Board of Directors

White Hall, Md.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  |                                                                          |                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|-----------------------------|
| D-655 72 08667                                                                                                                                                                                                                                                                                        |         | BALTIMORE CITY HEALTH DEPARTMENT                                                         |                  | 72 08667                                                                 |                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                             |         | REG. NO.                                                                                 |                  | STATE OF MARYLAND - DORMAN                                               |                             |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                |         | 2. DATE AND HOUR OF DEATH                                                                |                  | M.                                                                       |                             |
| DORMAN ADA. A.                                                                                                                                                                                                                                                                                        |         | 10:35 PM - 2235H. 9/5/1972                                                               |                  |                                                                          |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |                  |                                                                          |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                             |         | A. STATE                                                                                 |                  | B. COUNTY                                                                |                             |
| Church Home & Hospital - Balto MD. 21231.                                                                                                                                                                                                                                                             |         | Baptist Home of MD INC Park Heights Ave. Owing Mills MD.                                 |                  | C. CITY OR TOWN                                                          |                             |
|                                                                                                                                                                                                                                                                                                       |         | D. INSIDE CITY LIMITS?                                                                   |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                             |
|                                                                                                                                                                                                                                                                                                       |         | E. STREET AND NUMBER                                                                     |                  | Park Heights Ave. 530                                                    |                             |
| 5. SEX                                                                                                                                                                                                                                                                                                | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH | 9. AGE (in years last birthday)                                          | 10. Under 1 Yr. Months Days |
| F.                                                                                                                                                                                                                                                                                                    | W.      | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>            | 7-15-1883        | 89.                                                                      |                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                           |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                  | 11. BIRTHPLACE (State or foreign country)                                |                             |
| Homemaker                                                                                                                                                                                                                                                                                             |         |                                                                                          |                  | Virginia                                                                 |                             |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                          |         | 13. FATHER'S NAME                                                                        |                  | 14. MOTHER'S MAIDEN NAME                                                 |                             |
| American                                                                                                                                                                                                                                                                                              |         | Thomas Atkins.                                                                           |                  | Gloria White                                                             |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                              |         | 16. SOCIAL SECURITY NO.                                                                  |                  | 17. INFORMANT                                                            |                             |
| no                                                                                                                                                                                                                                                                                                    |         | 217-48-2864                                                                              |                  | Dr. J.W. Dorman Jr 1305 Roundhill Rd                                     |                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                    |         | CAUSE OF DEATH                                                                           |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                             |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                          |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |                                                                          |                             |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                     |         | Shock Secondary to                                                                       |                  |                                                                          |                             |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                             |         | Inferolateral Myocardial Infarction                                                      |                  |                                                                          |                             |
| (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                   |         | (C)                                                                                      |                  |                                                                          |                             |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                   |         |                                                                                          |                  |                                                                          |                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                |                             |
|                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  |                                                                          |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                 |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                             |
|                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  |                                                                          |                             |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                         |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                               |                             |
|                                                                                                                                                                                                                                                                                                       |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |                                                                          |                             |
| 22. I certify that (I) (this hospital) attended the deceased from 9/5/1972 to 9/5/1972 that (I) (we) last saw the deceased alive on 9/5/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                          |                             |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                        |         | 23B. DATE SIGNED                                                                         |                  |                                                                          |                             |
| M. YOUSUF SIDDIQUI MD                                                                                                                                                                                                                                                                                 |         | 9/5/1972                                                                                 |                  |                                                                          |                             |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                          |         | 23D. ADDRESS                                                                             |                  |                                                                          |                             |
| M. YOUSUF SIDDIQUI MD                                                                                                                                                                                                                                                                                 |         | Church Home & Hosp Balto MD. 21231.                                                      |                  |                                                                          |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                              |         | 24B. DATE                                                                                |                  | 24C. NAME OF CEMETERY OR CREMATORY                                       |                             |
| Burial                                                                                                                                                                                                                                                                                                |         | 9/8/72                                                                                   |                  | Baltimore Cemetery                                                       |                             |
| 24D. LOCATION (City, town, or county)                                                                                                                                                                                                                                                                 |         | 24E. LOCATION (State)                                                                    |                  |                                                                          |                             |
| North Ave Balto.                                                                                                                                                                                                                                                                                      |         | Md.                                                                                      |                  |                                                                          |                             |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                       |         | 25B. NAME OF REGISTRAR                                                                   |                  | 25C. FUNERAL DIRECTOR                                                    |                             |
| SEP 11 1972                                                                                                                                                                                                                                                                                           |         | Sidney L. Wiedefeld                                                                      |                  | Mitchell Wiedefeld Home 6500 York Rd.                                    |                             |

7/3/64 - Adm.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                 |                                                                                     |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 72 08668                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                 | 72 08668                                                                            |                                                           |
| BIRTH NO. 7-325                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | REG. NO. 72 08668                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                 | STATE OF MARYLAND-DEATH                                                             |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Daniel H. FitzSimons</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>Sept 7, 1972</b>                                                                                                                                                                                                                                                                                |                                                                                     |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Long Green Nursing Home</b>                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2712</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>204 Paddington Road</b> |                                                                                     |                                                           |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 6, 1886</b>                                                                                                                                                                                                                                                                                          | 9. AGE (In years last birthday)<br><b>86</b>                                        | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired V.Pres. American Brewery</b>                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>Evansville, Ind.</b>                                                                                                                                                                                                                                                            |                                                                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                |
| 13. FATHER'S NAME<br><b>Charles FitzSimons</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Anna Laughlin</b>                                                                                                                                                                                                                                                                                |                                                                                     |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>216-01-4162A</b>                                                                                                                                                                                                                                                                                  | 17. INFORMANT ADDRESS<br><b>Mrs. D. H. FitzSimons 204 Paddington</b>                |                                                           |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cancer of colon</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>metastasis</b><br>ROAD TO DEATH<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b> |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                 |                                                                                     |                                                           |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                 |                                                                                     |                                                           |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                 | 20A. AUTOPSY? (Yes or No)                                                           |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                 | 21F. HOW DID INJURY OCCUR?                                                          |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19 55</b> to <b>Sept 7 19 72</b> , that (I) (we) lost saw the deceased olive on <b>9-6 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                 |                                                                                     |                                                           |
| 23A. SIGNATURE<br><b>Franklin E. Leslie</b><br>DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                 | 23B. DATE SIGNED                                                                    |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>FRANKLIN LESLIE</b><br>DEGREE                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                 | 23D. ADDRESS<br><b>3501 St Paul St Baltimore Md.</b>                                |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><b>9/9/72</b>                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                 | 24C. NAME OF CEMETERY or CREMATORY<br><b>Dulaney Valley Mausoleum Timonium, Md.</b> |                                                           |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 25. DATE REC'D. BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                       |                                                                                                                                                                                                                                                                                                                                 |                                                                                     |                                                           |
| 25B. NAME OF REGISTRAR<br><b>Dudley Johnson</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Mitchell-Wiedefeld-Home 6500 York Rd</b>                                                                                |                                                                                                                                                                                                                                                                                                                                 |                                                                                     |                                                           |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                          |                            |                                                                                                                                                                       |                                          |                                                                                               |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                         |                            | 72 08669                                                                                                                                                              |                                          | 72 08669                                                                                      |                                                           |
| W-430                                                                                                                                                                                                                                                                                                                                    |                            | 72 08669                                                                                                                                                              |                                          | 72 08669                                                                                      |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                |                            | CERTIFICATE OF DEATH                                                                                                                                                  |                                          | REG. NO.                                                                                      |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>EUGENIA A. WILDE</b>                                                                                                                                                                                                                                                                           |                            | 2. DATE AND HOUR OF DEATH<br><b>Sept. 5, 1972 10:45 P.M.</b>                                                                                                          |                                          |                                                                                               |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                   |                            | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore county</b>                        |                                          |                                                                                               |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION Memorial Hosp.</b>                                                                                                                                                                                                                                                                      |                            | C. CITY OR TOWN<br><b>TOWSON</b>                                                                                                                                      |                                          | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| ADDRESS OR LOCATION<br><b>4 Balto. Md. 21218</b>                                                                                                                                                                                                                                                                                         |                            | E. STREET AND NUMBER<br><b>64 ACORN Circle APT. 204</b>                                                                                                               |                                          |                                                                                               |                                                           |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           | 8. DATE OF BIRTH<br><b>Sept 10, 1895</b> | 9. AGE (In years last birthday)<br><b>76 + 11 mos.</b>                                        | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work)<br><b>Admitting Officer</b>                                                                                                                                                                                                                                                                    |                            | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>                                                                                                                  |                                          | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                               |                            | 13. FATHER'S NAME<br><b>NOT known</b>                                                                                                                                 |                                          | 14. MOTHER'S MAIDEN NAME<br><b>NOT known</b>                                                  |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                 |                            | 16. SOCIAL SECURITY NO.<br><b>219-10-4551</b>                                                                                                                         |                                          | 17. INFORMANT<br><b>Miss Edith LAINSY</b>                                                     |                                                           |
| 18. <b>412.41</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CVA</b>                                                                                                         |                            | 19. CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><b>ASCVD</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Gangrene of foot due to 3 months ASCVD</b><br>(C) <b>ASCVD</b> |                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>                                 |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                   |                            |                                                                                                                                                                       |                                          |                                                                                               |                                                           |
| 19A. DATE OF OPERATION<br><b>Aug. 29, 1972</b>                                                                                                                                                                                                                                                                                           |                            | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>FAIR</b>                                                                                                       |                                          | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                        |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                        |                            | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                              |                                          | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                             |                            | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>                                                             |                                          | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 25 1972</b> to <b>Sept. 5 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept. 5 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                            |                                                                                                                                                                       |                                          |                                                                                               |                                                           |
| 23A. SIGNATURE<br><b>Manuel O. Rafanan MD</b>                                                                                                                                                                                                                                                                                            |                            | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                       |                                          | 23B. DATE SIGNED<br><b>Sept. 5, 1972</b>                                                      |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MANUEL O. RAFANAN</b>                                                                                                                                                                                                                                                                                 |                            | 23D. ADDRESS<br><b>UNION Memorial Hosp. Balto. Md.</b>                                                                                                                |                                          |                                                                                               |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                | 24B. DATE<br><b>9/8/72</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>                                                                                                     |                                          | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                   |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                    |                            | 25B. NAME OF REGISTRAR<br><b>Andrew Johnson</b>                                                                                                                       |                                          | 25C. FUNERAL DIRECTOR<br><b>Wm. Johnson</b>                                                   |                                                           |
| VS 150-REV. 1/1/68                                                                                                                                                                                                                                                                                                                       |                            |                                                                                                                                                                       |                                          | ADDRESS<br><b>8501 Loch Raven Balto. Md.</b>                                                  |                                                           |



Hospital

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12000

Manuel C. R. ...

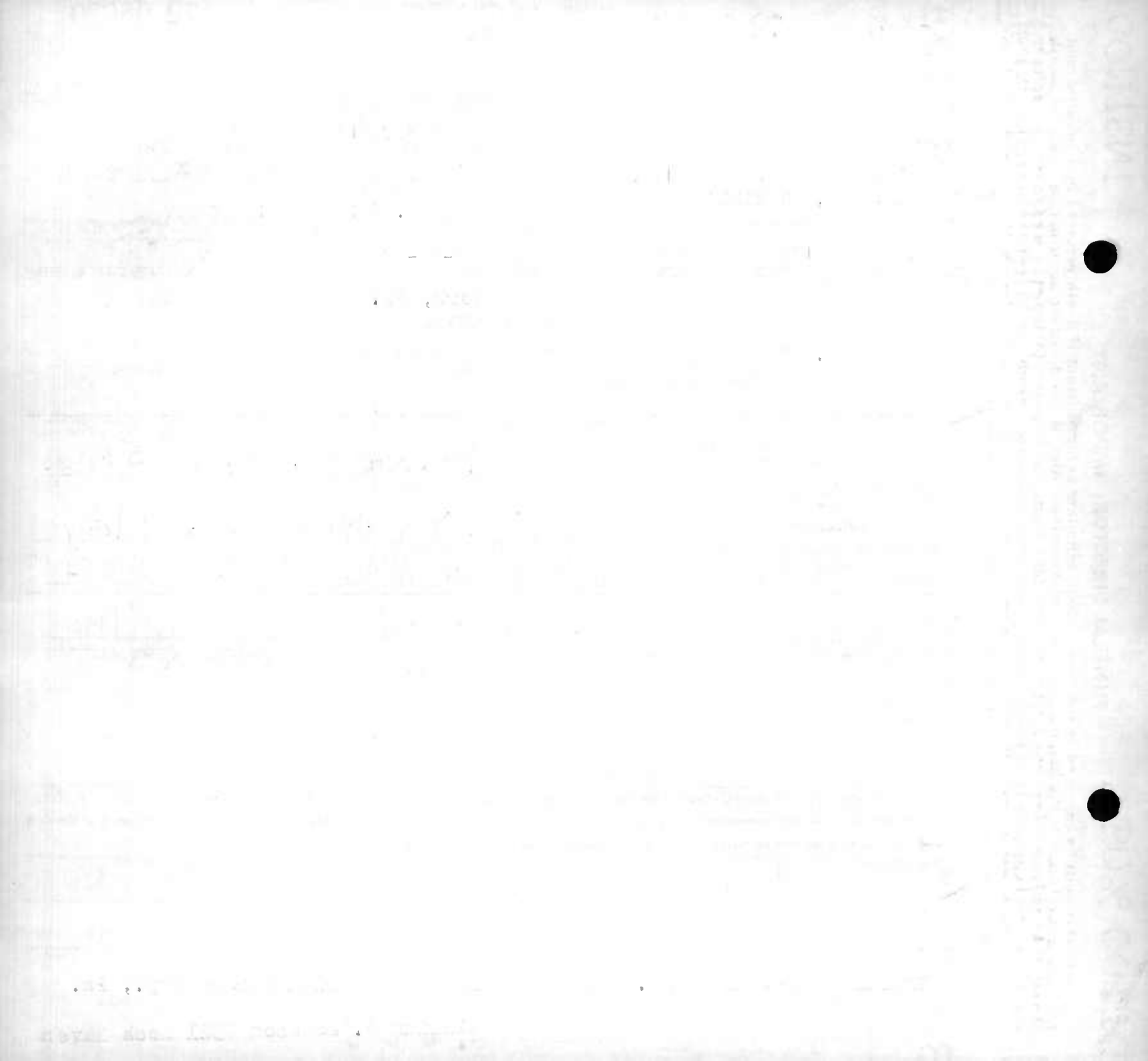
London East ...



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                                                                                                                                                                                               |                              |                                                                                               |                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| S-610 72 08670                                                                                                                                                                                                                                                                                                                       |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                              |                              | 72 08670                                                                                      |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                            |                  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                        |                              | 2. DATE AND HOUR OF DEATH                                                                     |                                                           |
| JASON SHARP                                                                                                                                                                                                                                                                                                                          |                  | 9/3/72                                                                                                                                                                                                                                                                                                                        |                              | 1 8 1/4 PM M.                                                                                 |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                               |                  | 4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission)<br>A. STATE B. COUNTY                                                                                                                                                                                                                    |                              |                                                                                               |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                           |                  | PENNSYLVANIA YORK                                                                                                                                                                                                                                                                                                             |                              |                                                                                               |                                                           |
| THE JOHNS HOPKINS HOSPITAL<br>BALTIMORE, MD 21205                                                                                                                                                                                                                                                                                    |                  | C. CITY OR TOWN<br>YORK                                                                                                                                                                                                                                                                                                       |                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
|                                                                                                                                                                                                                                                                                                                                      |                  | E. STREET AND NUMBER<br>1037 E. PHILADELPHIA STREET                                                                                                                                                                                                                                                                           |                              |                                                                                               |                                                           |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                                       | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                   | 8. DATE OF BIRTH<br>01-19-72 | 9. AGE (In years last birthday)<br>7                                                          | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                          |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                             |                              | 11. BIRTHPLACE (State or foreign country)<br>York, Pa.                                        |                                                           |
| 13. FATHER'S NAME<br>JAMES R. SHARP                                                                                                                                                                                                                                                                                                  |                  | 14. MOTHER'S MAIDEN NAME<br>DONNA NEWCOMER                                                                                                                                                                                                                                                                                    |                              |                                                                                               |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                             |                  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                       |                              | 17. INFORMANT ADDRESS                                                                         |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>PRESUMPTIVE CNS BLEED<br>(B) RENAL INTORTY ; HYPERNATREMIA<br>(C) CONGENITAL HEART DISEASE<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>HYPERTENSION |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 hours<br>? 1 day<br>BIRTH<br>7 mo           |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                              |                              | 20A. AUTOPSY? (Yes or No)<br>YES                                                              |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                                                                                                                                       |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                            |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                     |                              | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from SEPT 2 19 72 to SEPT 3 19 72 that (H) (we) last saw the deceased alive on SEPT 3 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                    |                  |                                                                                                                                                                                                                                                                                                                               |                              |                                                                                               |                                                           |
| 23A. SIGNATURE<br>Joseph T. Marino MD                                                                                                                                                                                                                                                                                                |                  | 23B. DATE SIGNED<br>SEPT. 3, 1972                                                                                                                                                                                                                                                                                             |                              | 23C. PHYSICIAN'S NAME (Type)<br>JOSEPH T. MARINO MD                                           |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                             |                  | 24B. DATE                                                                                                                                                                                                                                                                                                                     |                              | 24C. NAME of CEMETERY or CREMATORY                                                            |                                                           |
| Burial                                                                                                                                                                                                                                                                                                                               |                  | 9/5/72                                                                                                                                                                                                                                                                                                                        |                              | Mt. Rose Cemetery                                                                             |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                      |                  | 25B. NAME OF REGISTRAR                                                                                                                                                                                                                                                                                                        |                              | 25C. FUNERAL DIRECTOR ADDRESS                                                                 |                                                           |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                          |                  | William E. Johnson                                                                                                                                                                                                                                                                                                            |                              | 8521 Loch Raven                                                                               |                                                           |



REG. NO.

VS 151-REV. 1/1/68

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                             |                                                                      | 72 08672                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                             |                                                                      | REG. NO. 72 08672                                                                                                               |
| BIRTH NO. <u>S-535</u>                                                                                                                                                                                                                                                                                                                             |                                                                                                        | 1. NAME OF DECEASED<br>(Type or Print) <u>Alfred Sundheim</u>                                                                                               |                                                                      |                                                                                                                                 |
| 2. DATE AND HOUR OF DEATH<br><u>9/7/72</u> <u>2:36</u> P.M.                                                                                                                                                                                                                                                                                        |                                                                                                        | STATE OF MARYLAND - DEPT                                                                                                                                    |                                                                      |                                                                                                                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                             |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                                                       |                                                                      |                                                                                                                                 |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>SINAI HOSP. OF BALT., INC.</u>                                                                                                                                                                                                                                                                          |                                                                                                        | A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE CITY</u>                                                                                                         |                                                                      |                                                                                                                                 |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                               |                                                                                                        | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |                                                                      |                                                                                                                                 |
| E. STREET AND NUMBER<br><u>2805 Steele Rd.</u>                                                                                                                                                                                                                                                                                                     |                                                                                                        | <u>2740</u>                                                                                                                                                 |                                                                      |                                                                                                                                 |
| 5. SEX <u>MALE</u>                                                                                                                                                                                                                                                                                                                                 | 6. RACE <u>WHITE</u>                                                                                   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>AUG. 5, 1911</u>                              | 9. AGE (In years last birthday) <u>61</u>                                                                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>JEWELRY</u>                                                                                                                                                                                                                                      |                                                                                                        | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>RETAIL</u>                                                                                                          |                                                                      | 11. BIRTHPLACE (State or foreign country)<br><u>GERMANY</u>                                                                     |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                                                                                                                                                                         |                                                                                                        | 13. FATHER'S NAME<br><u>WILLIAM SUNDHEIMER</u>                                                                                                              |                                                                      |                                                                                                                                 |
| 14. MOTHER'S MAIDEN NAME<br><u>ELSE LOEWENSTEIN</u>                                                                                                                                                                                                                                                                                                |                                                                                                        | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>YES W.W. II ARMY</u>                         |                                                                      |                                                                                                                                 |
| 16. SOCIAL SECURITY NO.<br><u>218-09-7252</u>                                                                                                                                                                                                                                                                                                      |                                                                                                        | 17. INFORMANT<br><u>MRS. ERIKA SUNDHEIM, 2805 STEELE ROAD #21209</u>                                                                                        |                                                                      |                                                                                                                                 |
| 18. <u>47019 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><u>MYOCARDIAL INFARCTION</u>                                                                                                 |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                                                      |                                                                                                                                 |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br><u>ARTERIOSCLEROTIC HEART DISEASE</u>                                                                                                                                                                            |                                                                                                        | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                        |                                                                      |                                                                                                                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                 |
| 19A. DATE OF OPERATION<br><u>9/4</u>                                                                                                                                                                                                                                                                                                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       | 20A. AUTOPSY? (Yes or No)                                                                                                                                   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                                                                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |                                                                      |                                                                                                                                 |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                          | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |                                                                      |                                                                                                                                 |
| 22. I certify that (H) (this hospital) attended the deceased from <u>9/4</u> 19 <u>72</u> to <u>9/7</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/7</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                             |                                                                      |                                                                                                                                 |
| 23A. SIGNATURE<br><u>Jan Sunshine M.P.</u>                                                                                                                                                                                                                                                                                                         |                                                                                                        | 23B. DATE SIGNED<br><u>9/7/72</u>                                                                                                                           |                                                                      | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><u>JAN SUNSHINE M.D.</u>                                                                                                                                                                                                                                                                                           |                                                                                                        | 23D. ADDRESS<br><u>Sinai Hosp. of Balt., Inc, Balt, Md.</u>                                                                                                 |                                                                      |                                                                                                                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                          | 24B. DATE<br><u>9/8/72</u>                                                                             | 24C. NAME of CEMETERY or CREMATORY<br><u>BALTIMORE HEBREW</u>                                                                                               | 24D. LOCATION (City, town, or county)<br><u>BALTIMORE, MARYLAND</u>  | 24E. STATE<br><u>MARYLAND</u>                                                                                                   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                              | 25B. NAME OF REGISTRAR<br><u>[Signature]</u>                                                           | 25C. FUNERAL DIRECTOR<br><u>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>                                                                            |                                                                      |                                                                                                                                 |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                                                      |                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                       |                  | REG. NO. 72 08673                                                                                                                                                                    |                                                               |
| 7-655 72 08673                                                                                                                                                                                                                                                                                                                         |                  | STATE OF MARYLAND - DEMH                                                                                                                                                             |                                                               |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                 |                  | 2. DATE AND HOUR OF DEATH                                                                                                                                                            |                                                               |
| FRIEMAN, MAURICE                                                                                                                                                                                                                                                                                                                       |                  | SEPT 7, 1972 3:05 A.M.                                                                                                                                                               |                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                 |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)                                                                                                 |                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>Sinai Hospital of Baltimore, Inc<br>4-2                                                                                                                                                                                                                                                    |                  | A. STATE<br>MARYLAND                                                                                                                                                                 |                                                               |
|                                                                                                                                                                                                                                                                                                                                        |                  | B. COUNTY<br>BALTO                                                                                                                                                                   |                                                               |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                                                                     |                  | C. CITY OR TOWN<br>BALTIMORE                                                                                                                                                         |                                                               |
|                                                                                                                                                                                                                                                                                                                                        |                  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                   |                                                               |
|                                                                                                                                                                                                                                                                                                                                        |                  | E. STREET AND NUMBER<br>7408 SHIRLEY ROAD                                                                                                                                            |                                                               |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                         | 6. RACE<br>white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                          | 8. DATE OF BIRTH<br>11-27-11                                  |
|                                                                                                                                                                                                                                                                                                                                        |                  | 9. AGE (In years last birthday)<br>60                                                                                                                                                | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>BOOKKEEPER                                                                                                                                                                                                                              |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>TULKOFF CORP.                                                                                                                                   |                                                               |
| 11. BIRTHPLACE (State or foreign country)<br>RUSSIA                                                                                                                                                                                                                                                                                    |                  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                  |                                                               |
| 13. FATHER'S NAME<br>SOLOMON FRIEMAN                                                                                                                                                                                                                                                                                                   |                  | 14. MOTHER'S MAIDEN NAME<br>ROSE OPPEL                                                                                                                                               |                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or known) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                           |                  | 16. SOCIAL SECURITY NO.<br>216-05-8897                                                                                                                                               |                                                               |
|                                                                                                                                                                                                                                                                                                                                        |                  | 17. INFORMANT<br>MRS. ETHEL FRIEMAN, 7408 SHIRLEY ROAD #21207                                                                                                                        |                                                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) Myocardial Infarction.<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) |                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                 |                  |                                                                                                                                                                                      |                                                               |
| 19A. DATE OF OPERATION<br>none                                                                                                                                                                                                                                                                                                         |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                     |                                                               |
| 20A. AUTOPSY? (Yes or No)<br>none                                                                                                                                                                                                                                                                                                      |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                 |                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>no                                                                                                                                                                                                                                            |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                             |                                                               |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                            |                  |                                                                                                                                                                                      |                                                               |
| 21D. TIME OF INJURY (APPROX.)<br>1 Month ( ) Day ( ) Year ( ) Hour ( )                                                                                                                                                                                                                                                                 |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                            |                                                               |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                                                      |                                                               |
| 22. I certify that (H) (this hospital) attended the deceased from Aug 26, 1972 to Sept 7, 1972 that (H) (we) lost saw the deceased alive on Sept 7, 1972 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.                     |                  |                                                                                                                                                                                      |                                                               |
| 23A. SIGNATURE<br>Dorinda Boonsue MD                                                                                                                                                                                                                                                                                                   |                  | 23B. DATE SIGNED<br>9-7-72                                                                                                                                                           |                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br>SRISOOK BOONSUE MD                                                                                                                                                                                                                                                                                     |                  | 23D. ADDRESS<br>Sinai Hospital Balto MD 21215                                                                                                                                        |                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                     |                  | 24B. DATE<br>9/8/72                                                                                                                                                                  |                                                               |
| 24C. NAME OF CEMETERY or CREMATORY<br>HEBREW YOUNG MEN                                                                                                                                                                                                                                                                                 |                  | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE, MARYLAND                                                                                                                 |                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                         |                  | 25B. NAME OF REGISTRAR<br>A. J. [Signature]                                                                                                                                          |                                                               |
| 25C. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                                                  |                  | ADDRESS                                                                                                                                                                              |                                                               |

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                        | 72 08674                                                         | 72 08674                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                        | REG. NO.                                                         | STATE OF MARYLAND - DEHE                                  |
| BIRTH NO. <u>J-100</u>                                                                                                                                                                                                                                                                                                                                                                                         |                  | 1. NAME OF DECEASED<br>(Type or Print) <u>Jeppi, Lawrence Harry</u>                                                                                                                           |                                                                                                                                                                                                                                                                                                                                        | 2. DATE AND HOUR OF DEATH<br><u>9-7-72</u> <u>7:23</u> <u>PM</u> |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>37 Mercy Hospital</u>                                                                                                                                                                                                            |                  |                                                                                                                                                                                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>Baltimore</u><br>C. CITY OR TOWN <u>Baltimore</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>2578 Druid Park Drive</u> |                                                                  |                                                           |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                   | 8. DATE OF BIRTH <u>12-25-22</u> <u>91</u>                                                                                                                                                                                                                                                                                             | 9. AGE (In years last birthday) <u>80</u>                        | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Self-Employed</u>                                                                                                                                                                                                                                                                                            |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                        | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>  |                                                           |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                     |                  | 13. FATHER'S NAME <u>John Jeppi</u>                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                        | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>                          |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                       |                  | 16. SOCIAL SECURITY NO. <u>216-10-2173</u>                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                        | 17. INFORMANT <u>Emily F. Jeppi - Same</u>                       |                                                           |
| 18. I <u>1621</u> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><u>Antecedent Causes</u><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Anteriosclerotic Cardiovascular Disease</u> |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>Bronchogenic Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>with metastases</u><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                                                                                                                                                                                                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |                                                           |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                          |                  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Anteriosclerotic Cardiovascular Disease</u>               |                                                                                                                                                                                                                                                                                                                                        |                                                                  |                                                           |
| 19A. DATE OF OPERATION <u>2</u> <u>No</u>                                                                                                                                                                                                                                                                                                                                                                      |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No) <u>YES</u>                             |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>                                                                                                                                                                                                                                                                                                                                 |                  | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                       |                                                                                                                                                                                                                                                                                                                                        |                                                                  |                                                           |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                       |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                      |                                                                                                                                                                                                                                                                                                                                        | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)        |                                                           |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                              |                  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                        |                                                                  |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> <u>1972</u> to <u>9-7</u> <u>1972</u> , that (I) (we) lost saw the deceased alive on <u>9-7</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death.                                                             |                  |                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                        |                                                                  |                                                           |
| 23A. SIGNATURE <u>Terry P. Detrich, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                        | 23B. DATE SIGNED                                                 |                                                           |
| 23C. PHYSICIAN'S NAME (Type) <u>TERRY P. DETRICH, M.D.</u>                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                        | 23D. ADDRESS                                                     |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                       |                  | 24B. DATE                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                        | 24C. NAME OF CEMETERY or CREMATORY                               |                                                           |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                                                  |                  | 24E. DATE REC'D BY HEALTH DEPT.                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                        | 24F. NAME OF REGISTRAR                                           |                                                           |
| 24G. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                          |                  | 24H. ADDRESS                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                        |                                                                  |                                                           |
| 24I. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                                |                  | 24J. NAME OF REGISTRAR                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                        | 24K. FUNERAL DIRECTOR                                            |                                                           |
| 24L. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 24M. DATE REC'D BY HEALTH DEPT.                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                        |                                                                  |                                                           |

11-11-71

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

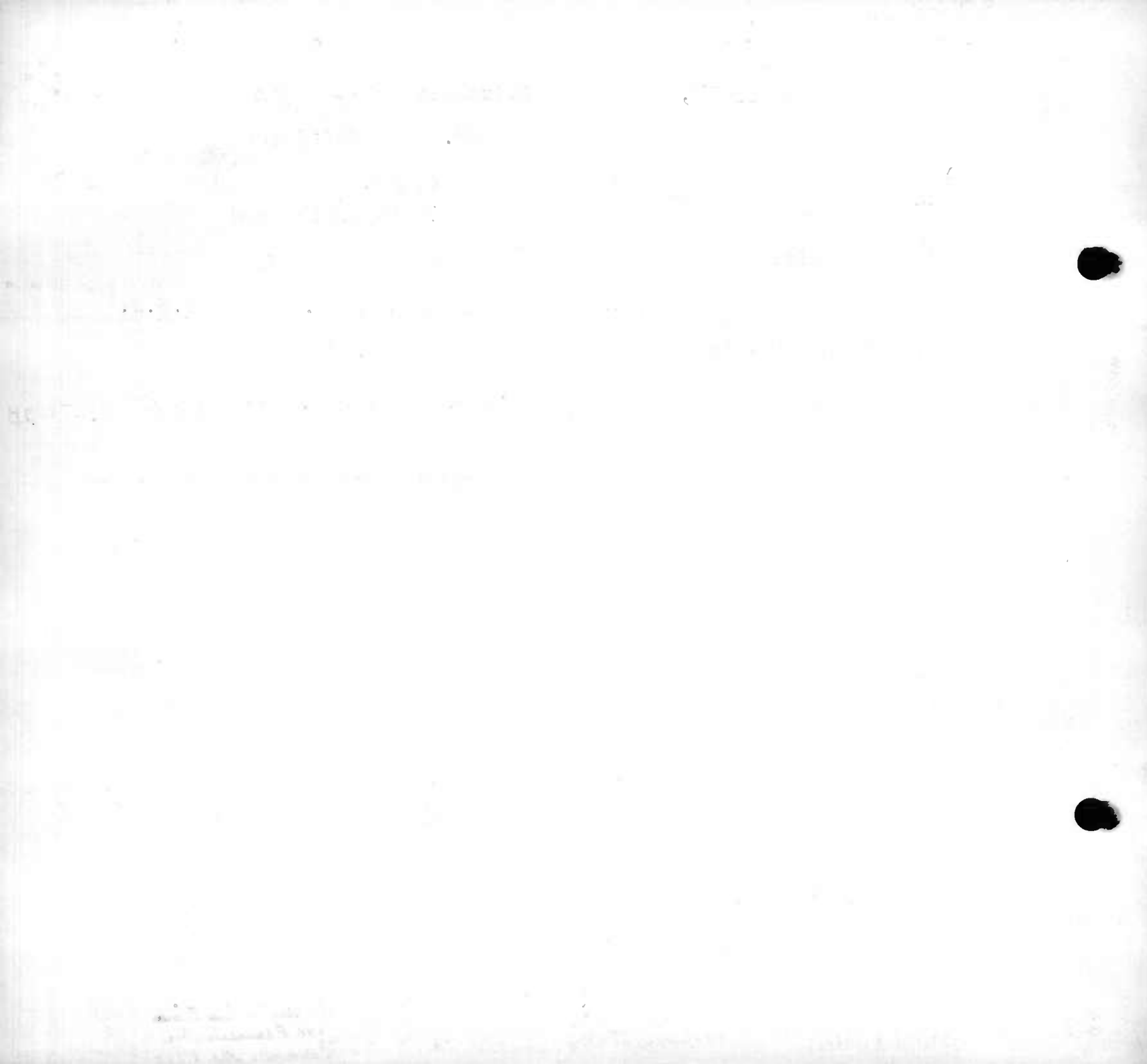
|                                                                                                                                                                                                                                                                                                                      |         |                                                                                          |                  |                                                                          |                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------|
| 72 08675                                                                                                                                                                                                                                                                                                             |         | BALTIMORE CITY HEALTH DEPARTMENT                                                         |                  | 72 08675                                                                 |                                |
| W-622                                                                                                                                                                                                                                                                                                                |         | 72 08675                                                                                 |                  | X                                                                        |                                |
| BIRTH NO.                                                                                                                                                                                                                                                                                                            |         | CERTIFICATE OF DEATH                                                                     |                  | REG. NO.                                                                 |                                |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                               |         | 2. DATE AND HOUR OF DEATH                                                                |                  | STATE OF MARYLAND-DEMT                                                   |                                |
| Melvin C. Worzask (Wrzask)                                                                                                                                                                                                                                                                                           |         | SEPTEMBER 6 1972 10 40 A.M.                                                              |                  |                                                                          |                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                               |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |                  |                                                                          |                                |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                            |         | A. STATE                                                                                 |                  | B. COUNTY                                                                |                                |
| South Baltimore General Hospital                                                                                                                                                                                                                                                                                     |         | Md.                                                                                      |                  | Balto.                                                                   |                                |
| 43                                                                                                                                                                                                                                                                                                                   |         | C. CITY OR TOWN                                                                          |                  | D. INSIDE CITY LIMITS?                                                   |                                |
|                                                                                                                                                                                                                                                                                                                      |         | 21204                                                                                    |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |                                |
|                                                                                                                                                                                                                                                                                                                      |         | E. STREET AND NUMBER                                                                     |                  |                                                                          |                                |
|                                                                                                                                                                                                                                                                                                                      |         | 1602 Myamby Road                                                                         |                  |                                                                          |                                |
| 5. SEX                                                                                                                                                                                                                                                                                                               | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH | 9. AGE (In years lost birthday)                                          | 10. If Under 1 Yr. Months Days |
| Male                                                                                                                                                                                                                                                                                                                 | White   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | Aug 29, 1923     | 49                                                                       |                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                          |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                  | 11. BIRTHPLACE (State or foreign country)                                |                                |
| Treasurer                                                                                                                                                                                                                                                                                                            |         | Furniture                                                                                |                  | Maryland                                                                 |                                |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                    |         | 14. MOTHER'S MAIDEN NAME                                                                 |                  | 12. CITIZEN OF WHAT COUNTRY?                                             |                                |
| Joseph E. Worzask                                                                                                                                                                                                                                                                                                    |         | Jessie Ziolkowski                                                                        |                  | USA                                                                      |                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                             |         | 16. SOCIAL SECURITY NO.                                                                  |                  | 17. INFORMANT ADDRESS                                                    |                                |
| Yes                                                                                                                                                                                                                                                                                                                  |         | Air Force WWII                                                                           |                  | 216-16-8569 Mrs. Constance W. Worzask Same                               |                                |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                   |         | CAUSE OF DEATH                                                                           |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                                |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                         |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  | 5 min                                                                    |                                |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                    |         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |                  | 20 yr.                                                                   |                                |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                            |         | (C)                                                                                      |                  |                                                                          |                                |
| II                                                                                                                                                                                                                                                                                                                   |         |                                                                                          |                  |                                                                          |                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                     |         |                                                                                          |                  |                                                                          |                                |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                               |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                |                                |
|                                                                                                                                                                                                                                                                                                                      |         |                                                                                          |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                      |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                               |                                |
| (APPROX.)                                                                                                                                                                                                                                                                                                            |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |                                                                          |                                |
| 22. I certify that (I) (this hospital) attended the deceased from January 19 71 to Sept. 19 72 that (I) (we) last saw the deceased alive on August 30 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                          |                                |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                       |         | 23B. DATE SIGNED                                                                         |                  |                                                                          |                                |
| Samuel L. O'Mansky                                                                                                                                                                                                                                                                                                   |         | 4/11/1972                                                                                |                  |                                                                          |                                |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                         |         | 23D. ADDRESS                                                                             |                  |                                                                          |                                |
| Samuel L. O'Mansky                                                                                                                                                                                                                                                                                                   |         | 8523 Loch Raven Blvd. 21204                                                              |                  |                                                                          |                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                             |         | 24B. DATE                                                                                |                  | 24C. NAME of CEMETERY or CREMATORY                                       |                                |
| Burial                                                                                                                                                                                                                                                                                                               |         | Sep 9, 1972                                                                              |                  | Dulaney Valley Mem Gar. Balto. Co., Md.                                  |                                |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                      |         | 25B. NAME OF REGISTRAR                                                                   |                  | 25C. FUNERAL DIRECTOR ADDRESS                                            |                                |
| SEP 11 1972                                                                                                                                                                                                                                                                                                          |         | Wm. E. Johnson                                                                           |                  | 8521 Loch Raven Blvd                                                     |                                |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                            |                                                                                       |                                                                    |                                                                                               |                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------|
| S-423                                                                                                                                                                                                                                                                                                                                                                                         |                         | 72 08676                                                                                                                                                    |                                            | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                                                                    | X REG. NO. 72 08676                                                                           |                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                            | STATE OF MARYLAND - DHMH                                                              |                                                                    |                                                                                               |                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Silcott, Clara Elizabeth</i>                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                            | 2. DATE AND HOUR OF DEATH<br><i>9-6-72</i> <i>2 P. M.</i>                             |                                                                    |                                                                                               |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                            | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                                                    |                                                                                               |                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Harbor View Nursing Home</i><br><i>1213 Light St</i>                                                                                                                                                                                                                                                                                               |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                                            | A. STATE<br><i>Md.</i>                                                                |                                                                    | B. COUNTY<br><i>Baltimore</i>                                                                 |                                               |
|                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                            | C. CITY OR TOWN<br><i>Baltimore</i>                                                   |                                                                    | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                               |
|                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                            | E. STREET AND NUMBER<br><i>638 Plymouth Road</i>                                      |                                                                    |                                                                                               |                                               |
| 5. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>4/9/72</i>          | 9. AGE (In years lost birthday)<br><i>71</i>                                          | If Under 1 Yr. Months Days                                         | If Under 24 Hrs. Hours Min.                                                                   |                                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>At Home</i>                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>----- |                                                                                       | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md.</i> |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |
| 13. FATHER'S NAME<br><i>James E. Silcott</i>                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                            | 14. MOTHER'S MAIDEN NAME<br><i>Mary E. Hannon</i>                                     |                                                                    |                                                                                               |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                                                                                         |                         | 16. SOCIAL SECURITY NO. <i>T. 212-36-7588</i>                                                                                                               |                                            | 17. INFORMANT ADDRESS<br><i>Mrs. Dorothy S. Russell - 638 Plymouth Rd. - 21228</i>    |                                                                    |                                                                                               |                                               |
| 18. <i>412.7 I</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                                                                    |                                                                                               |                                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>CVA, Dehydration</i>                                                                                                                                                                     |                         |                                                                                                                                                             |                                            | <i>1 Week</i>                                                                         |                                                                    |                                                                                               |                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                            | <i>ASCD</i><br><i>Years</i>                                                           |                                                                    |                                                                                               |                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                            |                                                                                       |                                                                    |                                                                                               |                                               |
| 19A. DATE OF OPERATION<br><i>0</i>                                                                                                                                                                                                                                                                                                                                                            |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                            | 20A. AUTOPSY? (Yes or No)                                                             |                                                                    | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                                                    |                                                                                               |                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                     |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                            | 21F. HOW DID INJURY OCCUR?                                                            |                                                                    |                                                                                               |                                               |
| 22. I certify that <i>He</i> (this hospital) attended the deceased from <i>April 3</i> 19 <i>69</i> to <i>September 6</i> 19 <i>72</i> that <i>He</i> (we) last saw the deceased alive on <i>September 6</i> 19 <i>72</i> and that <i>in my</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>He</i> (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                            |                                                                                       |                                                                    |                                                                                               |                                               |
| 23A. SIGNATURE<br><i>Peter H. Rheinstein, MD</i>                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                            | 23B. DATE SIGNED<br><i>September 6, 1972</i>                                          |                                                                    |                                                                                               |                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><i>PETER H. RHEINSTEIN, MD</i>                                                                                                                                                                                                                                                                                                                                |                         | 23D. ADDRESS<br><i>Harbor View Convalescent Center</i>                                                                                                      |                                            |                                                                                       |                                                                    |                                                                                               |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                     |                         | 24B. DATE<br><i>9/9/72</i>                                                                                                                                  |                                            | 24C. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral Cemetery</i>                   |                                                                    | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md.</i>                        |                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 11 1972</i>                                                                                                                                                                                                                                                                                                                                         |                         | 25B. NAME OF REGISTRAR<br><i>Audrey M. Rothman</i>                                                                                                          |                                            | 25C. FUNERAL DIRECTOR<br><i>Sterling Funeral Estate</i>                               |                                                                    | ADDRESS<br><i>356 Edmondson Ave. Catonsville, Md. 21228</i>                                   |                                               |



S-616

72 08677 STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT

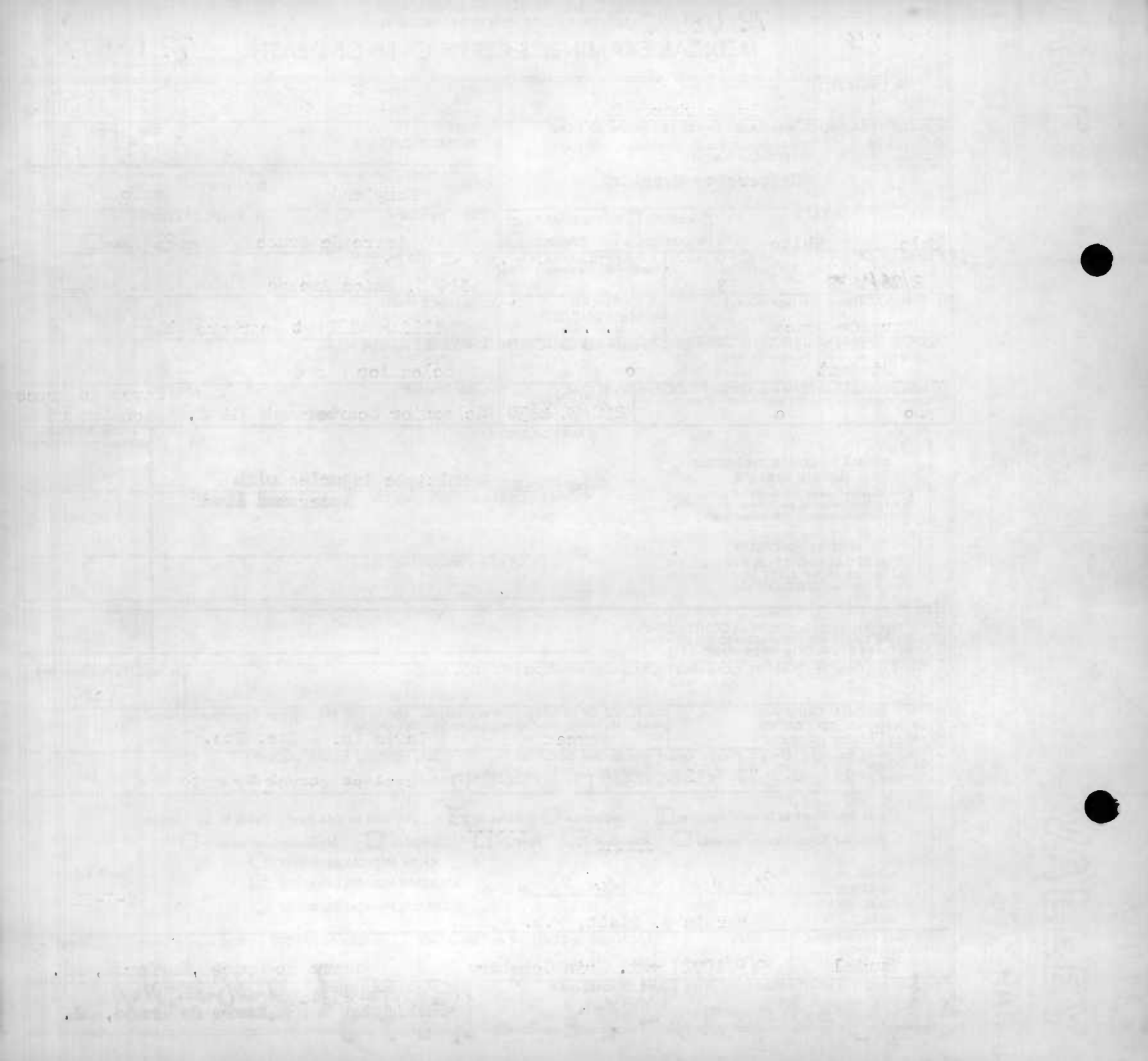
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08677

BIRTH NO.

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                                                                   |                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Billy Scarborough                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month 9 Day 6 Year 72 Hour 11:40P. M.                                                         |                                                                                    |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>University Hospital                                                                                                                                                                                                                                                                       |                  | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 6 Year 72 Hour 11:40P. M.                                                                                                                                  |                                                                                    |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY Harford                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                                                                   |                                                                                    |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7. RACE<br>White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                  | C. CITY OR TOWN<br>Havre de Grace                                                  |
| 9. DATE OF BIRTH<br>2/26/1959                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 10. AGE (In years last birthday)<br>13                                                                                                                                                            | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)<br>Havre de Grace                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                            | E. STREET AND NUMBER<br>314 S. Union Avenue                                        |
| 13. FATHER'S NAME<br>William Wilbert Scarborough                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                                                                   |                                                                                    |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Student                                                                                                                                                                                                                                                                                                                                                               |                  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Same                                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>Scleanior Lloyd                                        |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                       |                  | 17. SOCIAL SECURITY NO.<br>218 72 2830                                                                                                                                                            | 18. INFORMANT<br>Scleanior Scarborough                                             |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                      |                                                                                    |
| 20A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                  |                                                                                    |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                |                  | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)<br>Street                                                                                                |                                                                                    |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>Lewis La. & Ste. Rte. 7                                                                                                                                                                                                                                                                                                                                                                 |                  | 22E. HOW DID INJURY OCCUR?<br>Bicyclist struck by auto                                                                                                                                            |                                                                                    |
| 22D. TIME OF INJURY (APPROX.)<br>9 6 72 9:13P.                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 22F. HOW DID INJURY OCCUR?<br>Bicyclist struck by auto                                                                                                                                            |                                                                                    |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                       |                  |                                                                                                                                                                                                   |                                                                                    |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Marvin S. Platt, M.D.                                                                                                                                                                                                                                                                                                                                                                                                 |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br>9-7-72 |                                                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 24B. DATE<br>9/9/1972                                                                                                                                                                             |                                                                                    |
| 24C. NAME OF CEMETERY or CREMATORY<br>Mt. Erin Cemetery                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 24D. LOCATION (City, town, or county) (State)<br>Havre de Grace, Harford, Md.                                                                                                                     |                                                                                    |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 25B. NAME OF REGISTRAR<br>Sidney H. Heston                                                                                                                                                        |                                                                                    |
| 25C. FUNERAL DIRECTOR<br>Tennington & Son, Havre de Grace, Md.                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 25D. ADDRESS<br>Tennington & Son, Havre de Grace, Md.                                                                                                                                             |                                                                                    |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                       |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                 |  | 72 08678                              |  | 72 08678                                                                                                                                                                                                                                                                                                    |  | REG. NO. 72 08678                                                                          |  |
| BIRTH NO. 5-620                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                       |  | STATE OF MARYLAND-DEATH                                                                                                                                                                                                                                                                                     |  |                                                                                            |  |
| 1. NAME OF DECEASED<br>(Type or Print) SUAREZ, DANIEL FERNANDES                                                                                                                                                                                                                                                                                                                                                  |  |                                       |  | 2. DATE AND HOUR OF DEATH<br>SEPTEMBER 7, 1972 6:45A.M.                                                                                                                                                                                                                                                     |  |                                                                                            |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>40 ST. AGNES HOSPITAL                                                                                                                                                                                                                 |  |                                       |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY BALTIMORE 21228<br>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER 121 STONEWALL RD. 5300 |  |                                                                                            |  |
| 5. SEX MALE                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. RACE CAUCASIAN                     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                 |  | 8. DATE OF BIRTH 04 19 94                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                       |  | 9. AGE (In years lost birthday) 78                                                                                                                                                                                                                                                                          |  | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                              |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER & Mach. Operator                                                                                                                                                                                                                                                                                               |  |                                       |  | 10B. KIND OF BUSINESS OR INDUSTRY BAKERY                                                                                                                                                                                                                                                                    |  | 11. BIRTHPLACE (State or foreign country) SPAIN -Asturias                                  |  |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                                                                                                                                                                                                                                                                                              |  |                                       |  | 13. FATHER'S NAME JOSEPH SUAREZ                                                                                                                                                                                                                                                                             |  |                                                                                            |  |
| 14. MOTHER'S MAIDEN NAME MARIE (FERNANDES)                                                                                                                                                                                                                                                                                                                                                                       |  |                                       |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO                                                                                                                                                                                                 |  |                                                                                            |  |
| 16. SOCIAL SECURITY NO. 14225565                                                                                                                                                                                                                                                                                                                                                                                 |  |                                       |  | 17. INFORMANT RECORDS OF ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229                                                                                                                                                                                                                         |  |                                                                                            |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Carcinoma of the Lung.<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF<br>Fracture R hip<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>Tuberculosis.<br>(C) UNDERLYING CONDITION lost. |  |                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                       |  | MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                       |  |                                                                                            |  |
| 19A. DATE OF OPERATION None                                                                                                                                                                                                                                                                                                                                                                                      |  |                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                            |  | 20A. AUTOPSY? (Yes or No) No                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                   |  |                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home                                                                                                                                                                                                               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 121 Stonewall Rd. |  |
| 21D. TIME OF INJURY (APPROX.) 9-5-72 6:00 PM                                                                                                                                                                                                                                                                                                                                                                     |  |                                       |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                                                                                                                                                                           |  | 21F. HOW DID INJURY OCCUR? Collapsed to floor                                              |  |
| 22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 05 19 72 to SEPTEMBER 07 19 72, that (X) (we) last saw the deceased alive on SEPTEMBER 7 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.                                                                                  |  |                                       |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                            |  |
| 23A. SIGNATURE Benavides M.D.                                                                                                                                                                                                                                                                                                                                                                                    |  |                                       |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                                                                                                             |  | 23B. DATE SIGNED 09 08 07 72                                                               |  |
| 23C. PHYSICIAN'S NAME (Type) VICTOR BENAVIDES M.D.                                                                                                                                                                                                                                                                                                                                                               |  |                                       |  | 23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229                                                                                                                                                                                                                                                        |  |                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE 9/9/72                      |  | 24C. NAME OF CEMETERY or CREMATORY Crest Lawn Memorial Gardens-Harford County, Md.                                                                                                                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State) Sand Hill Road-                              |  |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR Audrey Johnson |  | 25C. FUNERAL DIRECTOR Sterling Funeral Estate                                                                                                                                                                                                                                                               |  | ADDRESS 729 Edmondson Ave. Catonsville, Md. 21228                                          |  |

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(230144737) 24 844

25 50 75

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                             |                                                     | 72 08679                                                                                                                                            |                                                                                               | REG. NO. 72 08679                                                                             |                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------|
| BIRTH NO. 1-000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             |                                                     | STATE OF MARYLAND-DEATH                                                                                                                             |                                                                                               |                                                                                               |                                            |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY C. LEE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             |                                                                                                                                                             |                                                     | 2. DATE AND HOUR OF DEATH<br><b>SEPTEMBER 6, 1972 3:40 A M.</b>                                                                                     |                                                                                               |                                                                                               |                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |                                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE COUNTY</b> |                                                                                               |                                                                                               |                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             |                                                     | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                 |                                                                                               | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             |                                                     | E. STREET AND NUMBER<br><b>32 DUNMORE ROAD</b>                                                                                                      |                                                                                               | <b>21228</b>                                                                                  |                                            |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE<br><b>CAUCASIAN</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>04 10 86</b>                 | 9. AGE (In years last birthday)<br><b>86</b>                                                                                                        | If Under 1 Yr. Months: Days: Hours: Min.                                                      |                                                                                               |                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                   |                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                  |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
| 13. FATHER'S NAME<br><b>JOHN CLOPE IN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>(SPIKELMAN) MARY</b> |                                                                                                                                                     |                                                                                               |                                                                                               |                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>212-52-1564</b>       |                                                                                                                                                     | 17. INFORMANT<br><b>RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b> |                                                                                               |                                            |
| 18. <b>4369 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Central failure</b><br><b>CVA</b>                                                                                                                                                                                                                                                         |                             |                                                                                                                                                             |                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                        |                                                                                               |                                                                                               |                                            |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                                                                                                                      |                             |                                                                                                                                                             |                                                     | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                                                          |                                                                                               |                                                                                               |                                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |                                                     |                                                                                                                                                     |                                                                                               |                                                                                               |                                            |
| 19A. DATE OF OPERATION<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                     | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                              |                                                                                               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                         |                                                                                               |                                                                                               |                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                     | 21F. HOW DID INJURY OCCUR?                                                                                                                          |                                                                                               |                                                                                               |                                            |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 5, 19 72</b> to <b>SEPTEMBER 6, 19 72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>SEPTEMBER 6, 19 72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. |                             |                                                                                                                                                             |                                                     |                                                                                                                                                     |                                                                                               |                                                                                               |                                            |
| 23A. SIGNATURE<br><i>Kuang-yen Huang</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             |                                                     | 23B. DATE SIGNED<br><b>09 06 72</b>                                                                                                                 |                                                                                               |                                                                                               |                                            |
| 23C. PHYSICIAN'S NAME (Type)<br><b>KUANG-YEN HUANG, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                                                                                                                                             |                                                     | 23D. ADDRESS<br><b>BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>                                                                 |                                                                                               |                                                                                               |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | 24B. DATE<br><b>9-9-1972</b>                                                                                                                                |                                                     | 24C. NAME of CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>                                                                                   |                                                                                               | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                   |                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | 25B. NAME OF REGISTRAR<br><i>Sidney Hubbard</i>                                                                                                             |                                                     | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                          |                                                                                               | ADDRESS                                                                                       |                                            |

SEPTEMBER 6, 1972 3:40 A

SEP, 1972

MARYLAND BALTIMORE COUNTY

BALTIMORE

32 DUNMORE ROAD 21228

04 10 86 86

XX FEMALE CAUCASIAN

MARYLAND

(SPIKELMAN) MARY

JOHN CLOPEIN

ST AGNES HOSPITAL WILKINS & CATON AVE  
RECORDS BALTIMORE MD 21228

NO

NO

SEPTEMBER 6, 1972

XX

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SEPTEMBER 6, 1972

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X

XX

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09 06 72

X

BALTIMORE MD 21228

ST AGNES HOSPITAL WILKINS & CATON AVE

KUANG-YEN HUANG, M.D.

BALTIMORE MARYLAND

BALTIMORE MD 21228

SEPTEMBER 6, 1972

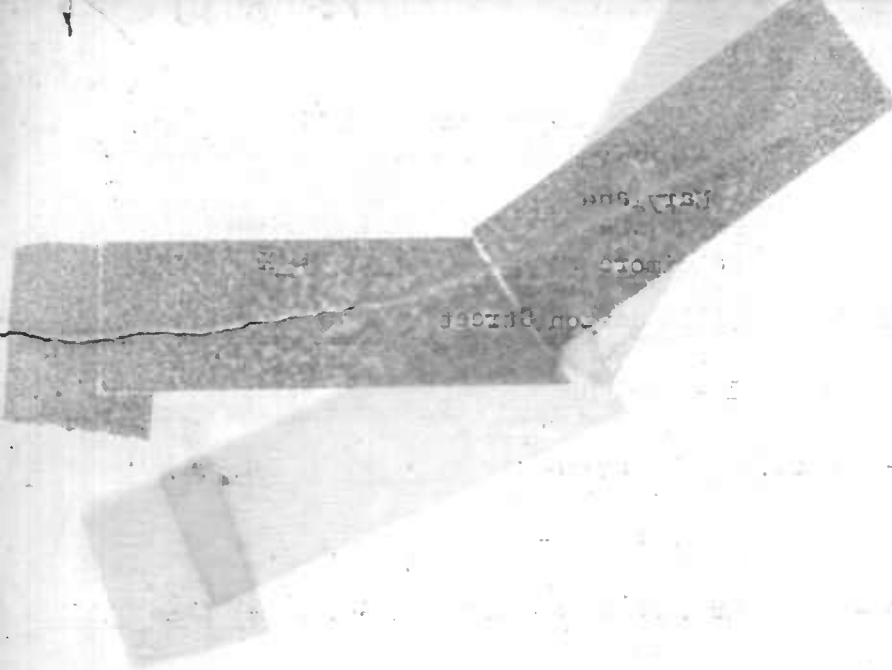
NO

RECORDS BALTIMORE MD 21228

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  | 72 08680                                                                                                                                                    |  | BIRTH NO.                              |  | 72 08680                                                                                                                                                                                                                                                                                                                       |  | CERTIFICATE OF DEATH       |  | REG. NO.                                                                    |  | 72 08680 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------|--|-----------------------------------------------------------------------------|--|----------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MABEL P. KELLY</b>                                                                                                                                                                                                                                                                                                                                     |  |                         |  |                                                                                                                                                             |  |                                        |  | 2. DATE AND HOUR OF DEATH<br><b>September 6, 1972</b> <b>10</b> M.                                                                                                                                                                                                                                                             |  |                            |  |                                                                             |  |          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1716 Sexton Street<br/>Baltimore, Maryland 21230</b>                                                                                                                                                               |  |                         |  |                                                                                                                                                             |  |                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2553</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1716 Sexton Street</b> |  |                            |  |                                                                             |  |          |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 6. RACE<br><b>White</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10- 22-1905</b> |  | 9. AGE (In years last birthday)<br><b>66</b>                                                                                                                                                                                                                                                                                   |  | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min.                                                 |  |          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Packer</b>                                                                                                                                                                                                                                                                                     |  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland Glass Corp.</b>                                                                                            |  |                                        |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                   |  |                            |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |  |          |  |
| 13. FATHER'S NAME<br><b>John Henry Riley</b>                                                                                                                                                                                                                                                                                                                                                     |  |                         |  |                                                                                                                                                             |  |                                        |  | 14. MOTHER'S MAIDEN NAME<br><b>Katie Stumpf</b>                                                                                                                                                                                                                                                                                |  |                            |  |                                                                             |  |          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                         |  |                         |  | 16. SOCIAL SECURITY NO.<br><b>215-05-6403</b>                                                                                                               |  |                                        |  | 17. INFORMANT ADDRESS<br><b>Mrs. Jane Manzer, 1176 St. Agnes Lane 21207</b>                                                                                                                                                                                                                                                    |  |                            |  |                                                                             |  |          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>myocardial failure</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF<br><b>Anteroseptal Heart Disease</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>10 year</b><br>(C) _____ |  |                         |  |                                                                                                                                                             |  |                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                                                                                                                                                                                                                                                                  |  |                            |  |                                                                             |  |          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION<br><b>9/6</b>                                                                                                                                                                                                                   |  |                         |  |                                                                                                                                                             |  |                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>1962 to 9/6 1972</b>                                                                                                                                                                                                                                                    |  |                            |  |                                                                             |  |          |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                          |  |                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  |                                        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                       |  |                            |  |                                                                             |  |          |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                        |  |                         |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  |                                        |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                     |  |                            |  |                                                                             |  |          |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1962</b> to <b>9/6</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                         |  |                         |  |                                                                                                                                                             |  |                                        |  |                                                                                                                                                                                                                                                                                                                                |  |                            |  |                                                                             |  |          |  |
| 23A. SIGNATURE<br><b>Dr. N. Erskine per John P. Urlock, Jr.</b>                                                                                                                                                                                                                                                                                                                                  |  |                         |  |                                                                                                                                                             |  |                                        |  |                                                                                                                                                                                                                                                                                                                                |  |                            |  | 23B. DATE SIGNED<br><b>9/8/72</b>                                           |  |          |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>John P. Urlock, Jr.</b>                                                                                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                                             |  |                                        |  | 23D. ADDRESS<br><b>1227 Washington Blvd., Balto., Md.</b>                                                                                                                                                                                                                                                                      |  |                            |  |                                                                             |  |          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                        |  |                         |  | 24B. DATE<br><b>9-9-1972</b>                                                                                                                                |  |                                        |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Western Cemetery</b>                                                                                                                                                                                                                                                                  |  |                            |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                                                            |  |                         |  | 25B. NAME OF REGISTRAR<br><b>Howard H. Hubbard</b>                                                                                                          |  |                                        |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                                                |  |                            |  |                                                                             |  |          |  |



12/1/68  
12/1/68  
12/1/68





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                           |               |                                                                                                                                                          |                          | REG. NO. 72 08681                                                                          |                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| 72 08681                                                                                                                                                                                                                                                                                                                   |               |                                                                                                                                                          |                          | STATE OF MARYLAND-DEMD                                                                     |                                                                                                    |
| BIRTH NO. 1                                                                                                                                                                                                                                                                                                                |               | NAME OF DECEASED (Type or Print) DOUGLAS, JOSEPH ALLAN                                                                                                   |                          | 2. DATE AND HOUR OF DEATH 7/7/72 6:00 A.M.                                                 |                                                                                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                     |               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA B. COUNTY                                        |                          |                                                                                            |                                                                                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD. BALTIMORE, MARYLAND 21218                                                                                                                                 |               | C. CITY OR TOWN ARLINGTON                                                                                                                                |                          | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                    |
| E. STREET AND NUMBER 1740 N. 14th Street                                                                                                                                                                                                                                                                                   |               |                                                                                                                                                          |                          |                                                                                            |                                                                                                    |
| 5. SEX MALE                                                                                                                                                                                                                                                                                                                | 6. RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-10-25 | 9. AGE (In years last birthday) 47                                                         | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                |               | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |                          | 11. BIRTHPLACE (State or foreign country) MARKHAM, VIRGINIA                                |                                                                                                    |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                                                                                                                                                                                                        |               |                                                                                                                                                          |                          |                                                                                            |                                                                                                    |
| 13. FATHER'S NAME OSCAR M. DOUGLAS                                                                                                                                                                                                                                                                                         |               | 14. MOTHER'S MAIDEN NAME DAISIE GOUGH                                                                                                                    |                          |                                                                                            |                                                                                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) YES                                                                                                                                                                                                                                                      |               | 16. SOCIAL SECURITY NO. 9-10-42 to 11-10-45 231 22 80-32                                                                                                 |                          | 17. INFORMANT ADDRESS CLINICAL RECORDS-VAH BALTO MD.                                       |                                                                                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |               | CAUSE OF DEATH Small Bowel Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Mesenteric Artery Thrombosis (B) (C)                           |                          |                                                                                            |                                                                                                    |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                           |               | Post Op Regain Gastrointestinal Function - Generally Deleterious                                                                                         |                          |                                                                                            |                                                                                                    |
| 19A. DATE OF OPERATION 9-6-72                                                                                                                                                                                                                                                                                              |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Suspected bowel Infarction                                                                              |                          | 20A. AUTOPSY? (Yes or No) YES                                                              |                                                                                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                      |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |                                                                                                    |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                            |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                          | 21F. HOW DID INJURY OCCUR?                                                                 |                                                                                                    |
| 22. I certify that (X) (this hospital) attended the deceased from 5-31-1972 to 9-7-1972, that (X) (we) lost saw the deceased alive on 9-7-72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (do not) view the body after death.                        |               |                                                                                                                                                          |                          |                                                                                            |                                                                                                    |
| 23A. SIGNATURE Kenneth A. Krackow                                                                                                                                                                                                                                                                                          |               | 23B. DATE SIGNED 9/7/72                                                                                                                                  |                          | 23C. PHYSICIAN'S NAME (Type) KENNETH A. KRACKOW, M.D.                                      |                                                                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                            |               | 24B. DATE 9/10/72                                                                                                                                        |                          | 24C. NAME OF CEMETERY or CREMATORY Arlington Va.                                           |                                                                                                    |
| 24D. LOCATION (City, town, or county) Howard H. Hubbard, 4107 Wilkens Ave.                                                                                                                                                                                                                                                 |               | 24E. STATE (State) ARRLINGTON, VA                                                                                                                        |                          |                                                                                            |                                                                                                    |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 11 1972                                                                                                                                                                                                                                                                                |               | 25B. NAME OF REGISTRAR Sidney Hubbard                                                                                                                    |                          | 25C. FUNERAL DIRECTOR ADDRESS                                                              |                                                                                                    |

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO: SAC, HONOLULU  
FROM: SAC, SAN FRANCISCO  
SUBJECT: [illegible]

RE: [illegible]

[illegible]

3-9-64

1-10-64

RE: [illegible]  
H.D.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                             |  | 72 08682                                                                                                                                                                           | 72 08682 | REG. NO.                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                          |          | STATE OF MARYLAND-DHMH                                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              | Bayliss, Julia T.                                                                                                                                           |  | 9-5-72                                                                                                                                                                             |          | P. M.                                                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                              |          |                                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>37 Mercy HOSPITAL                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |  | A. STATE<br>Maryland                                                                                                                                                               |          |                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |  | B. COUNTY<br>Anne Arundel                                                                                                                                                          |          |                                                                             |
| C. CITY OR TOWN<br>Linthicum                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      |          |                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |  | E. STREET AND NUMBER<br>619 Timothy Dr. 5202                                                                                                                                       |          |                                                                             |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br>W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>11-25-08                                                                                                                                                       |          | 9. AGE (In years last birthday)<br>63                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Homemaker                                                                                                                                                                                                                                                                                                                                                          |              | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br>Pennsylvania                                                                                                                          |          | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                      |
| 13. FATHER'S NAME<br>Martin Concavage                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br>Mary Pahutka                                                                                                                                           |          |                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                 |              | 16. SOCIAL SECURITY NO.                                                                                                                                     |  | 17. INFORMANT<br>Mr. John J. Bayliss, 619 Timothy Drive                                                                                                                            |          |                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |  | ADDRESS<br>21090                                                                                                                                                                   |          |                                                                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |              |                                                                                                                                                             |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>A S C U D<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) acute massive myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) |          |                                                                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                            |              |                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                   |          | 20A. AUTOPSY? (Yes or No)                                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                           |          | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                      |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                         |          |                                                                             |
| 22. I certify that (1) (this hospital) attended the deceased from 9.5.72 to 9.5.72, that (1) (we) last saw the deceased alive on 9.5.72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.                                                                                                                                                             |              |                                                                                                                                                             |  |                                                                                                                                                                                    |          |                                                                             |
| 23A. SIGNATURE<br>Michael F. Plott, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                             |  | 23B. DATE SIGNED<br>9.6.72                                                                                                                                                         |          | 23C. PHYSICIAN'S NAME (Type)<br>MICHAEL F. PLOTT MD                         |
| 23D. ADDRESS<br>301 ST. PAUL PLACE                                                                                                                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                             |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                 |          |                                                                             |
| 24B. DATE<br>9-9-1972                                                                                                                                                                                                                                                                                                                                                                                                                                             |              | 24C. NAME of CEMETERY or CREMATORY<br>Meadowridge Cemetery                                                                                                  |  | 24D. LOCATION (City, town, or county) (State)<br>Wash. Blvd. Howard Co., Md.                                                                                                       |          |                                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                                                                    |              | 25B. NAME OF REGISTRAR<br>Sidney Johnson                                                                                                                    |  | 25C. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229                                                                                                                |          |                                                                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                               |  |                                                                                       |  |                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| S-200                                                                                                                                                                                                                                                                                                                           |  | 72 08683                                                                                      |  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |  | REG. NO. 72 08683                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                       |  |                                                                                               |  | STATE OF MARYLAND-DHMH                                                                |  |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                          |  |                                                                                               |  | 2. DATE AND HOUR OF DEATH                                                             |  |                                                                      |  |
| SISKEY, EARL G                                                                                                                                                                                                                                                                                                                  |  |                                                                                               |  | SEPTEMBER 5, 1972 2:15P M.                                                            |  |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                          |  |                                                                                               |  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)  |  |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                    |  |                                                                                               |  | A. STATE B. COUNTY                                                                    |  |                                                                      |  |
| ST. AGNES HOSPITAL                                                                                                                                                                                                                                                                                                              |  |                                                                                               |  | MARYLAND BALTIMORE                                                                    |  |                                                                      |  |
| 40                                                                                                                                                                                                                                                                                                                              |  |                                                                                               |  | C. CITY OR TOWN D. INSIDE CITY LIMITS?                                                |  |                                                                      |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                       |  |                                                                                               |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |                                                                      |  |
| E. STREET AND NUMBER                                                                                                                                                                                                                                                                                                            |  |                                                                                               |  | F. INSIDE CITY LIMITS?                                                                |  |                                                                      |  |
| 4930 GATEWAY TERRACE                                                                                                                                                                                                                                                                                                            |  |                                                                                               |  | 21227                                                                                 |  |                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                          |  | 6. RACE                                                                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 8. DATE OF BIRTH                                                     |  |
| MALE                                                                                                                                                                                                                                                                                                                            |  | CAUCASIAN                                                                                     |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 12/03/13                                                             |  |
| 9. AGE (In years lost birthday)                                                                                                                                                                                                                                                                                                 |  | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                     |  | 11. BIRTHPLACE (State or foreign country)                            |  |
| 58                                                                                                                                                                                                                                                                                                                              |  | TRUCK DRIVER                                                                                  |  | TRANSPORT CO                                                                          |  | MARYLAND                                                             |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                               |  |                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?                                                          |  |                                                                      |  |
| GEORGE SISKEY                                                                                                                                                                                                                                                                                                                   |  |                                                                                               |  | U.S.A.                                                                                |  |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                        |  |                                                                                               |  | 16. SOCIAL SECURITY NO.                                                               |  | 17. INFORMANT ADDRESS                                                |  |
| YES                                                                                                                                                                                                                                                                                                                             |  |                                                                                               |  | 215-10-5228                                                                           |  | Mrs. Ruby Siskey, 4930 Gateway Terrace 21227                         |  |
| W W 2                                                                                                                                                                                                                                                                                                                           |  |                                                                                               |  | ST. AGNES HOSPITAL RECORDS                                                            |  |                                                                      |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                              |  |                                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |                                                                      |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                  |  |                                                                                               |  | 1 month.                                                                              |  |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                      |  |                                                                                               |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                               |  |                                                                                               |  | Metastatic carcinoma to the brain                                                     |  |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                       |  |                                                                                               |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |  |                                                                      |  |
| Branchogenic carcinoma to lung                                                                                                                                                                                                                                                                                                  |  |                                                                                               |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                   |  |                                                                      |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                             |  |                                                                                               |  |                                                                                       |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                              |  | 20A. AUTOPSY? (Yes or No)                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                               |  | No                                                                                    |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)      |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                   |  | 21E. INJURY OCCURRED                                                                          |  | 21F. HOW DID INJURY OCCUR?                                                            |  |                                                                      |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                     |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>             |  |                                                                                       |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from August 17, 1972 to September 5, 1972, that (I) (we) last saw the deceased alive on September 5, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                               |  |                                                                                       |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                  |  |                                                                                               |  | 23B. DATE SIGNED                                                                      |  |                                                                      |  |
| Chumbar Prukadong M.D.                                                                                                                                                                                                                                                                                                          |  |                                                                                               |  | September 5, 1972                                                                     |  |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                    |  |                                                                                               |  | 23D. ADDRESS                                                                          |  |                                                                      |  |
| CHUMBAR PRUKADONG M.D.                                                                                                                                                                                                                                                                                                          |  |                                                                                               |  | BALTO, MD 21229                                                                       |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                        |  |                                                                                               |  | 24B. DATE                                                                             |  |                                                                      |  |
| Burial                                                                                                                                                                                                                                                                                                                          |  |                                                                                               |  | 9-9-1972                                                                              |  |                                                                      |  |
| 24C. NAME OF CEMETERY or CREMATORY                                                                                                                                                                                                                                                                                              |  |                                                                                               |  | 24D. LOCATION (City, town, or county) (State)                                         |  |                                                                      |  |
| Meadowridge Cemetery                                                                                                                                                                                                                                                                                                            |  |                                                                                               |  | Wash. Blvd. Howard Co., Md.                                                           |  |                                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR                                                                        |  | 25C. FUNERAL DIRECTOR                                                                 |  | ADDRESS                                                              |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                     |  | Sidney Hubbard                                                                                |  | Howard H. Hubbard                                                                     |  | 4107 Wilkens Ave. 21229                                              |  |

SEPTEMBER 2, 1932

TICKET, EARL D

MARYLAND BALTIMORE

ST. AGNES HOSPITAL

4330 GATEWAY TERRACE TICKET

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MALE CAUCASIAN

MARYLAND U.S.A.

TRUCK DRIVER FRANKFORT CO

AMANDA GRAY TICKET

GEORGE TICKET

ST. AGNES HOSPITAL RECORD

YES

ST. AGNES HOSPITAL 6 WILKINS AVE  
BALTIMORE MD 21202

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

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BALTIMORE CITY HEALTH DEPARTMENT

72 08684

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>EUGENE J. NOVAK</b>                                                                                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 4727 Luerksen Avenue</b>                                                                                                                                                                                                                                        |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 6, 1972 9:15 A.</b>                         |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br><b>White</b>                                                                                    |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                        |  |
| 9. DATE OF BIRTH<br><b>July 4, 1905</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 10. AGE (In years last birthday) <b>67</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.       |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>                                                                                                                                                                                                                                                                                                                                                           |  | 12. CITIZEN OF<br><b>U.S.A.</b>                                                                            |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Window Washer</b>                                                                                                                                                                                                                                                                                                  |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                          |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                 |  | 17. SOCIAL SECURITY NO.<br><b>167-07-0740</b>                                                              |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Sophie Tomczyk</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 18. INFORMANT<br><b>Mr Theodore Novak</b>                                                                  |  |
| 19. CAUSE OF DEATH<br><b>Fatty metamorphosis of liver</b>                                                                                                                                                                                                                                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                               |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                       |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                     |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                       |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                        |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                     |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                        |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                 |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                             |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                  |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                            |  | 22F. HOW DID INJURY OCCUR?                                                                                 |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                            |  |
| ACTUAL SIGNATURE<br><b>W P Mulloy</b> M.D.                                                                                                                                                                                                                                                                                                                                                                           |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                            |  |
| EXAMINER'S NAME (Type)<br><b>William P. Mulloy, M.D.</b>                                                                                                                                                                                                                                                                                                                                                             |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                      |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br><b>9/9/72</b>                                                                                 |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Redeemer</b>                                                                                                                                                                                                                                                                                                                                                           |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br><b>A. J. Ruck</b>                                                                |  |
| 25C. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc,</b>                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS<br><b>Baltimore, Md</b>                                                                            |  |

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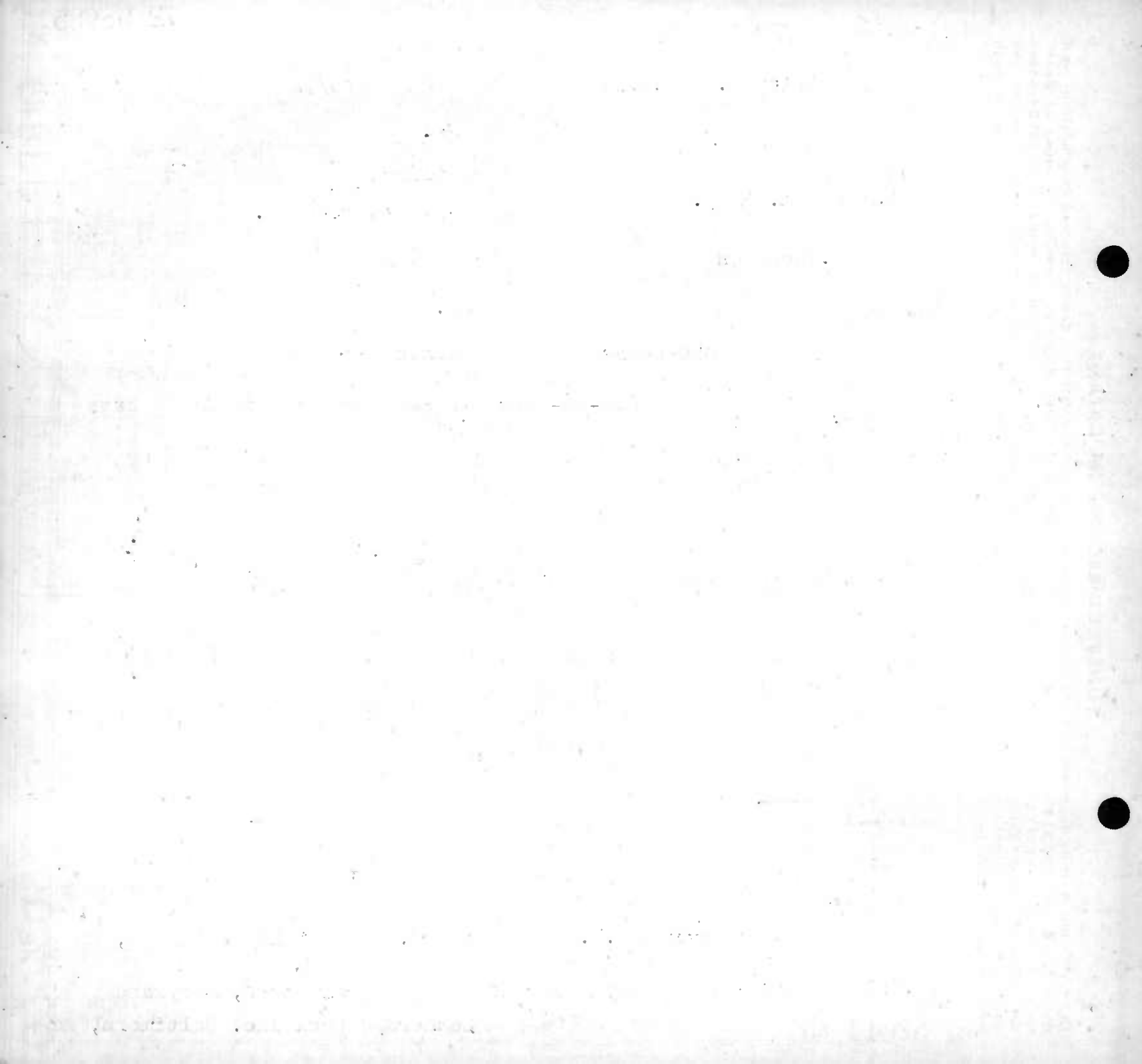
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |  |                                                                                                                                                                |                                       |                                                                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------------------------------------------|--|
| D-632                                                                                                                                                                                                                                                                                                                                                      |                      | 72 08685                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                               |                                       | REG. NO. 72 08685                                                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |  | STATE OF MARYLAND - DIME                                                                                                                                       |                                       |                                                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) Shirley M. Dardozzi                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br>9/8/72 6 A.M.                                                                                                                     |                                       |                                                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                          |                                       |                                                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>44 Union Mem. Hosp.                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             |  | A. STATE<br>Md.                                                                                                                                                |                                       | B. COUNTY<br>2832                                                                                    |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                   |                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  |
|                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |  | E. STREET AND NUMBER<br>4518 Furley Ave.                                                                                                                       |                                       |                                                                                                      |  |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br>Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>1/24/1930                                                                                                                                  | 9. AGE (In years lost birthday)<br>42 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             |  | 11. BIRTHPLACE (State or foreign country)<br>Md.                                                                                                               |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                  |  |
| 13. FATHER'S NAME<br>Cheeseman                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br>Elsie Kavanagh                                                                                                                     |                                       |                                                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br>218-26-1850                                                                                                                         |                                       | 17. INFORMANT<br>Mr Anthony J Dardizzi                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |  | ADDRESS<br>Same                                                                                                                                                |                                       |                                                                                                      |  |
| 18. 4/0-01<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.             |                      |                                                                                                                                                             |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary thrombosis probable</i><br>(B) SEVERE HYPERTENSION<br>(C) SEVERE CORONARY D. |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Hours or Days</i><br><i>Years</i><br><i>Years</i> |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                     |                      |                                                                                                                                                             |  |                                                                                                                                                                |                                       |                                                                                                      |  |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                      |                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                 |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                      |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                    |                                       |                                                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                               |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                     |                                       |                                                                                                      |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 1969 to 9-8-72, that (I) ( <del>we</del> ) last saw the deceased alive on 8-28-72 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |                      |                                                                                                                                                             |  |                                                                                                                                                                |                                       |                                                                                                      |  |
| 23A. SIGNATURE<br>William P. Benson, Jr. MD                                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             |  | 23B. DATE SIGNED<br>9-8-72                                                                                                                                     |                                       | 23C. PHYSICIAN'S NAME (Type)<br>William Benson M.D.                                                  |  |
| 23D. ADDRESS<br>3506 N. Calvert St Baltimore, Md                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             |  |                                                                                                                                                                |                                       |                                                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                         |                      | 24B. DATE<br>9/11/72                                                                                                                                        |  | 24C. NAME OF CEMETERY or CREMATORY<br>Holy Redeemer                                                                                                            |                                       | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                                             |                      | 25B. NAME OF REGISTRAR<br>Sidney Johnston                                                                                                                   |  | 25C. FUNERAL DIRECTOR<br>Leonard J Ruck Inc. Baltimore, Md                                                                                                     |                                       |                                                                                                      |  |

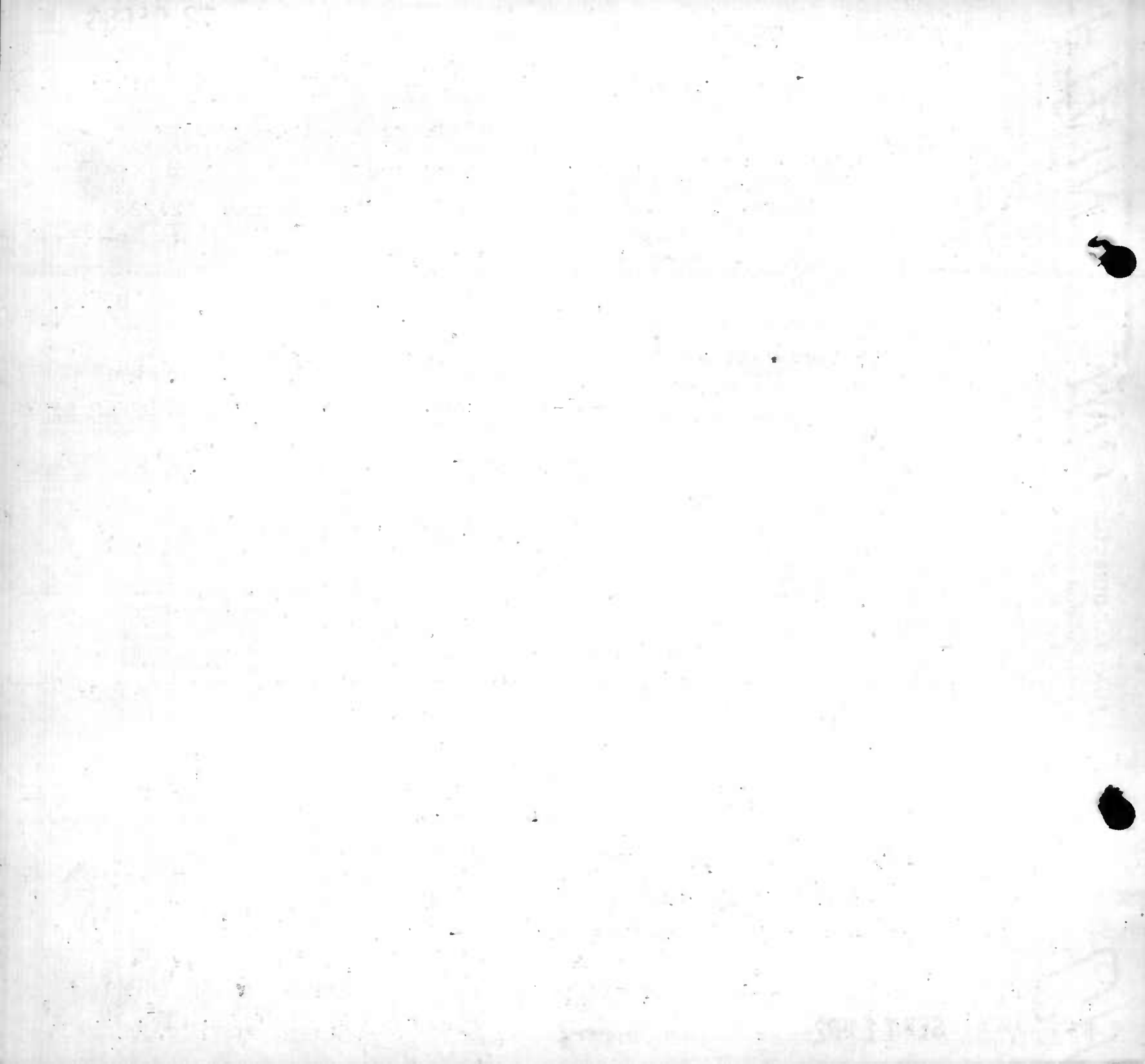




# FUNERAL DIRECTOR: IMPORTANT

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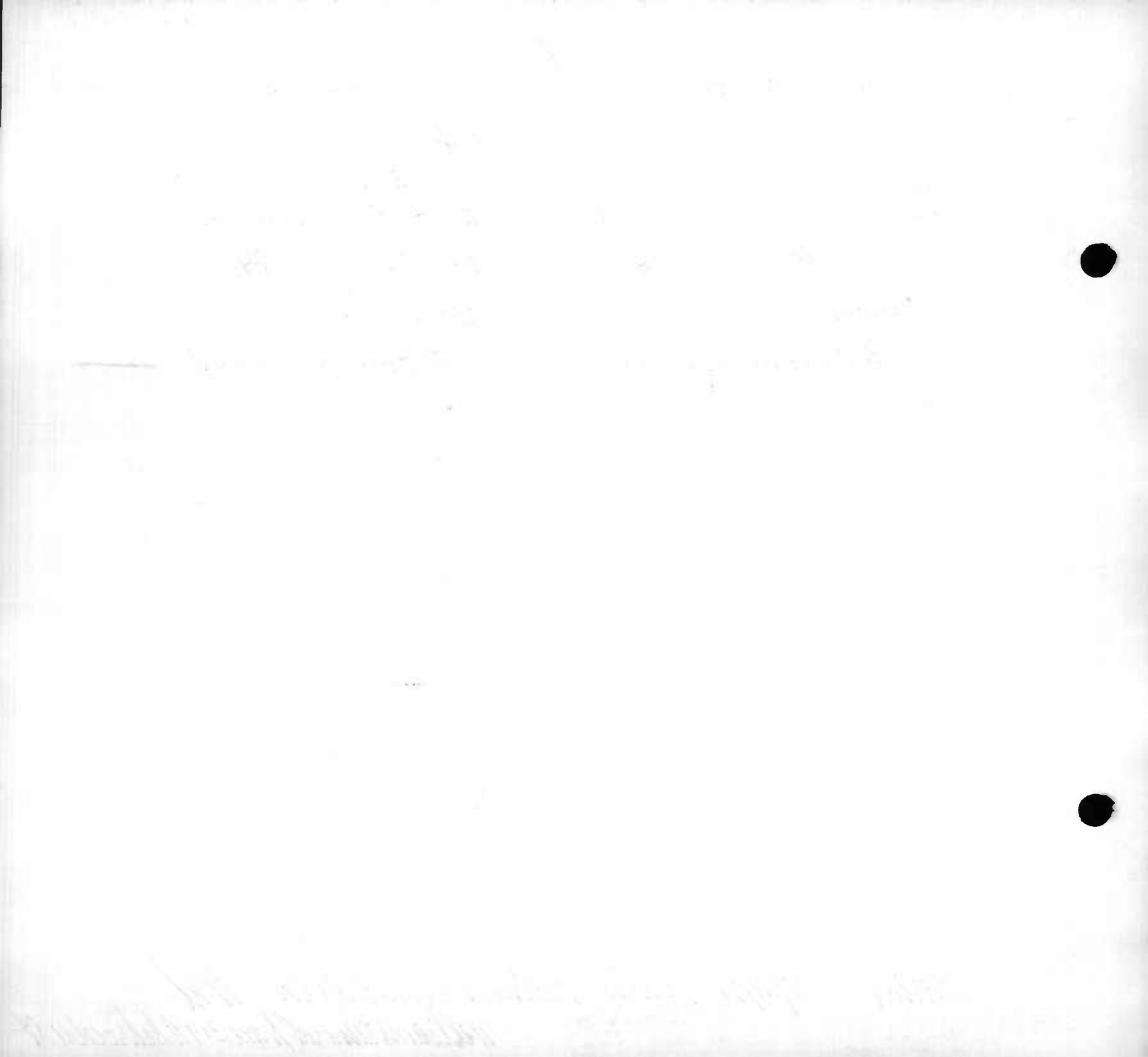
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| M-320                                                                                                                                                                                                                                                                                                   |  | 72 08686                                                                                                                                               |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                         |  | REG. NO. 72 08686                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                               |  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                 |  | 2. DATE AND HOUR OF DEATH                                                                                |  | STATE OF MARYLAND - DIME                                             |  |
|                                                                                                                                                                                                                                                                                                         |  | WILLIAM MATTHEWS                                                                                                                                       |  | 9/3/72 19:30 P.M.                                                                                        |  |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                  |  | A. STATE                                                                                                 |  | B. COUNTY                                                            |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>90                                                                                                                                                                                                                                                              |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Caton Manor Nursing Center<br>3330 Wilkens Avenue<br>Baltimore, Maryland 21229 |  | Baltimore Baltimore City                                                                                 |  | 5300                                                                 |  |
| 5. SEX                                                                                                                                                                                                                                                                                                  |  | 6. RACE                                                                                                                                                |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                    |  | 8. DATE OF BIRTH                                                     |  |
| Male                                                                                                                                                                                                                                                                                                    |  | Negro                                                                                                                                                  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                       |  | 1/24/15 57                                                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                      |  | 11. BIRTHPLACE (State or foreign country)                                                                |  | 12. CITIZEN OF WHAT COUNTRY?                                         |  |
|                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                        |  | Maryland                                                                                                 |  | U.S.A.                                                               |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                       |  | 14. MOTHER'S MAIDEN NAME                                                                                                                               |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.                                              |  |
| Williams Matthews                                                                                                                                                                                                                                                                                       |  | Gertrude Brooks                                                                                                                                        |  |                                                                                                          |  | 705-07-7570                                                          |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                           |  | ADDRESS                                                                                                                                                |  | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| Mrs. Sarah Matthews                                                                                                                                                                                                                                                                                     |  | Same as above                                                                                                                                          |  | 4/12/71                                                                                                  |  | 2 days                                                               |  |
| 19. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                       |  | 20A. AUTOPSY (Yes or No)                                                                                 |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 0                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                        |  | No                                                                                                       |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                 |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |  |                                                                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                               |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                 |  | 21F. HOW DID INJURY OCCUR?                                                                               |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4/13 1972 to 9/3 1972, that (I) (we) last saw the deceased alive on 9/3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                        |  |                                                                                                          |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                          |  | 23B. DATE SIGNED                                                                                                                                       |  | 23C. PHYSICIAN'S NAME (Type)                                                                             |  | 23D. ADDRESS                                                         |  |
| Herbert J. Leuckas, M.D.                                                                                                                                                                                                                                                                                |  | 9/4/72                                                                                                                                                 |  | Herbert J. Leuckas, M.D.                                                                                 |  | 5404 East Drive (21227)                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                |  | 24B. DATE                                                                                                                                              |  | 24C. NAME OF CEMETERY OR CREMATORY                                                                       |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                  |  | 9-8-72                                                                                                                                                 |  | Meadowridge Cemetery                                                                                     |  | Dorsey Maryland                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR                                                                                                                                 |  | 25C. FUNERAL DIRECTOR                                                                                    |  | ADDRESS                                                              |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                             |  | S. J. [Signature]                                                                                                                                      |  | Robert L. Snowden                                                                                        |  | 246 N. Wash. St. Rockville, Md. 20850                                |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                    |                                                                   |                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>C-200</span> <span>72 08687</span> </div>                                                                                                                                                                                                                                        |                  | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                             |                                                                                                                                                                                                                                                                                                                                    | 72-08687<br>REG. NO.                                              |                                                                                                                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Chase, Alethia Frances</b>                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>9/8/72 1:15 A</b> M.                                                                                                                                                                                                                                                                               |                                                                   |                                                                                                                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>University of Md. Hospital</b>                                                                                                                                        |                  |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Baltimore City</b> C. CITY OR TOWN <b>Baltimore City</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2112 N. Schroeder St.</b> |                                                                   |                                                                                                                                 |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                     | 6. RACE <b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>3-8-03</b>                                                                                                                                                                                                                                                                                                     | 9. AGE (in years last birthday) <b>69</b>                         | If Under 1 Yr. Months: Days: Hours: Min.<br>If Under 24 Hrs.                                                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                       |                  |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>                                                                                                                                                                                                                                                                                      |                                                                   |                                                                                                                                 |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                         |                                                                   |                                                                                                                                 |
| 13. FATHER'S NAME<br><b>Alexander Spencer</b>                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hammond</b>                                                                                                                                                                                                                                                                                    |                                                                   |                                                                                                                                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>X</b>                                                                                                                                                                                                                                |                  |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>212-05-3245</b>                                                                                                                                                                                                                                                                                      |                                                                   |                                                                                                                                 |
| 17. INFORMANT<br><b>pt.'s chart</b>                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                             | ADDRESS<br><b>unknown</b>                                                                                                                                                                                                                                                                                                          |                                                                   |                                                                                                                                 |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic Renal Failure</b>                                                                                                |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                    |                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b>                                                                    |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Endotoxemic Shock</b>                                                                                                                                                                                          |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                    |                                                                   | <b>2 wks</b>                                                                                                                    |
| (c) <b>Sepsis</b>                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                    |                                                                   | <b>3 wks</b>                                                                                                                    |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>—</b>                                                                                                                                                                                                  |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                    |                                                                   |                                                                                                                                 |
| 19A. DATE OF OPERATION<br><b>9/8/72</b>                                                                                                                                                                                                                                                                                                             |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                                                                                                |                                                                                                                                                                                                                                                                                                                                    | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                            |                                                                                                                                 |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>—</b>                                                                                                                                                                                                                                                                    |                  | (If in Baltimore City, give exact location)                                                                                                                 |                                                                                                                                                                                                                                                                                                                                    |                                                                   |                                                                                                                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>—</b>                                                        |                                                                                                                                                                                                                                                                                                                                    | 21C. WHERE DID INJURY OCCUR?<br><b>—</b>                          |                                                                                                                                 |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br><b>—</b>                                                                                                                                                                                                                                                                               |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                    | 21F. HOW DID INJURY OCCUR?<br><b>—</b>                            |                                                                                                                                 |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/25</b> 19 <b>72</b> to <b>9/8</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>9/8</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                    |                                                                   |                                                                                                                                 |
| 23A. SIGNATURE<br><b>Thomas Murphy</b>                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                             | 23B. DATE SIGNED<br><b>9/8/72</b>                                                                                                                                                                                                                                                                                                  |                                                                   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Thomas Murphy</b>                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             | 23D. ADDRESS<br><b>UNIVERSITY HOSPITAL</b>                                                                                                                                                                                                                                                                                         |                                                                   |                                                                                                                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                           |                  | 24B. DATE<br><b>9/11/72</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National Cem.</b> |                                                                                                                                 |
| 24D. LOCATION (City, town or county)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                           |                  | 24E. STATE<br><b>Md.</b>                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                    |                                                                   |                                                                                                                                 |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                               |                  | 25B. NAME OF REGISTRAR<br><b>Andrew M. ...</b>                                                                                                              |                                                                                                                                                                                                                                                                                                                                    | 25C. FUNERAL DIRECTOR<br><b>Williams Funeral Home</b>             |                                                                                                                                 |
| ADDRESS<br><b>3198 Schroeder St.</b>                                                                                                                                                                                                                                                                                                                |                  | 25D. CITY, STATE, ZIP<br><b>Baltimore, Md. 21218</b>                                                                                                        |                                                                                                                                                                                                                                                                                                                                    |                                                                   |                                                                                                                                 |



FUNERAL DIRECTOR: IMPORTANT

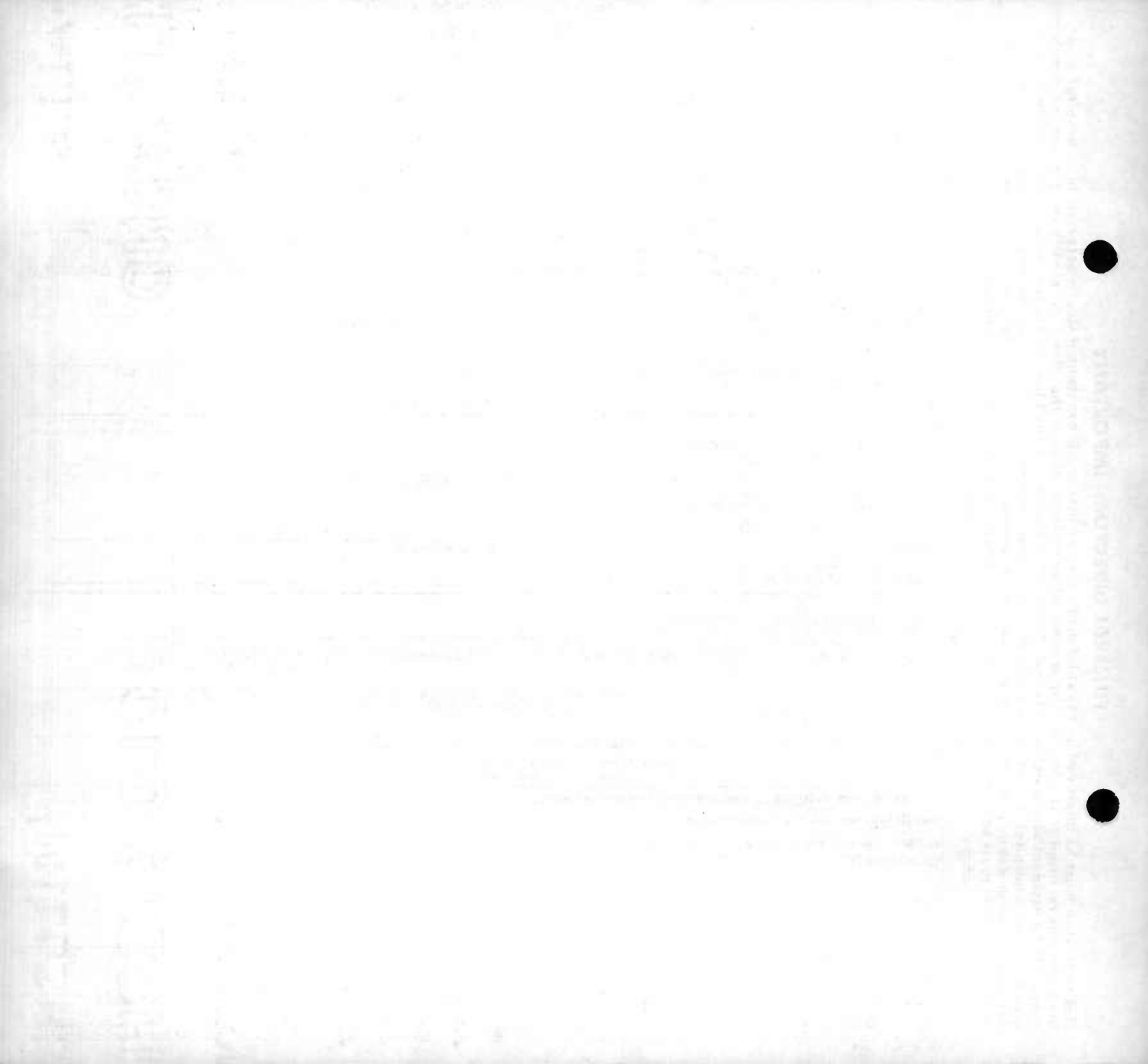
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 08688

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 08688  
STATE OF MARYLAND-DHMH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                    |                                                                                                                                                                                                                                                                                                                                    |                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>ROSE DAVIS</b>                                                                                                    |                                    | 2. DATE AND HOUR OF DEATH<br><b>SEPTEMBER 4 1972 12:30 A.M.</b>                                                                                                                                                                                                                                                                    |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b><br><b>43</b>                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>932 S. HANOVER ST.</b> |                                                           |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. RACE<br><b>NEGRO</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-28-04</b> | 9. AGE (in years last birthday)<br><b>68</b>                                                                                                                                                                                                                                                                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>SOUTH CAROLINA</b>                                                                                                                                                                                                                                                                 |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 13. FATHER'S NAME<br><b>SIMON RICHERSON</b>                                                                                                                 |                                    | 14. MOTHER'S MAIDEN NAME<br><b>ISEBELLE RHODES</b>                                                                                                                                                                                                                                                                                 |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                      |                                    | 17. INFORMANT<br><b>Mrs. Thelma McHoney</b> ADDRESS <b>932 Hanover St</b>                                                                                                                                                                                                                                                          |                                                           |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>410.91</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>CHRONIC OBSTRUCTIVE AIRWAY DISEASE</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>CHRONIC OBSTRUCTIVE AIRWAY DISEASE</b> |                         |                                                                                                                                                             |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 Hrs</b><br><b>3+ DAYS</b><br><b>YEARS</b>                                                                                                                                                                                                                                    |                                                           |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                                                                                                                                                                                                             |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                           |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                         |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 2 1972</b> to <b>9-4-72</b> 19 <b>72</b><br>that (I) (we) last saw the deceased alive on <b>9-4</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                    |                                                                                                                                                                                                                                                                                                                                    |                                                           |
| 23A. SIGNATURE<br><b>Theodore H. Cryer M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                    | 23B. DATE SIGNED<br><b>SEPT. 4, 1972</b>                                                                                                                                                                                                                                                                                           |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>THEODORE H. CRYER M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 23D. ADDRESS<br><b>SOUTH BALTIMORE GEN'L HOSPITAL</b><br><b>3001 S HANOVER STREET</b>                                                                       |                                    |                                                                                                                                                                                                                                                                                                                                    |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 24B. DATE<br><b>9-8-72</b>                                                                                                                                  |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Maryland National Cem.</b>                                                                                                                                                                                                                                                                |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>Laurel, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                       |                                    |                                                                                                                                                                                                                                                                                                                                    |                                                           |
| 25B. NAME OF REGISTRAR<br><b>Signey B. [Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 25C. FUNERAL DIRECTOR<br><b>Arlington S. Phillips</b> ADDRESS <b>1727 N. Monroe Street</b>                                                                  |                                    |                                                                                                                                                                                                                                                                                                                                    |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|
| 72 08689<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO. 72 08689<br>STATE OF MARYLAND-DEMH                                                                                       |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | DATE AND HOUR OF DEATH                                                                                                            |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>THOMAS, EDGAR</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 9-8-72 3:55 AM M.                                                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>2631</u> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>90 HARBOUR VIEW NURSING HOME BALTO MD</u>                                                                                                                                                                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  |
| 5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                            |  | 8. DATE OF BIRTH <u>7/7/15</u> 9. AGE (In years lost birthday) <u>57</u>                                                          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRON WORKER</u>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>                                                                         |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                           |  |
| 13. FATHER'S NAME <u>EDGAR THOMAS</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 14. MOTHER'S MAIDEN NAME <u>WEIGAND</u>                                                                                           |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16. SOCIAL SECURITY NO. <u>218-03-5191</u>                                                                                        |  |
| 17. INFORMANT <u>EDWARD THOMAS</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS <u>4313 GLENMORE AVE</u>                                                                                                  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>185X I</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Congestive Heart Failure</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Year</u>                                                                     |  |
| 19A. DATE OF OPERATION <u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                              |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                          |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                         |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 21F. HOW DID INJURY OCCUR?                                                                                                        |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>August 29</u> 19 <u>72</u> to <u>September 8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>September 8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                    |  |                                                                                                                                   |  |
| 23A. SIGNATURE<br><u>Peter H. Rheinstein, MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 23B. DATE SIGNED<br><u>Sept 1972</u>                                                                                              |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>PETER H. RHEINSTEIN, MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23D. ADDRESS<br><u>HARBOR VIEW CONVALESCENT CENTER</u>                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br><u>9/11/72</u>                                                                                                       |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><u>PARKWOOD CEMETERY</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br><u>TAYLOR AVE BALTO, MD</u>                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR<br><u>Adeline W. Weston</u>                                                                                |  |
| 25C. FUNERAL DIRECTOR<br><u>Colt 7000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS<br><u>Wendell</u>                                                                                                         |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08690

BIRTH NO.

STATE OF MARYLAND

1. NAME OF DECEASED  
(Type or Print)

LELIA BROWN

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1148 N. Carrollton Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

September 9, 1972

1:00 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7-20-20

10. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1148 N. Carrollton Avenue

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jim Peterkin

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lizzie Davis

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Anna B. Bailey 3818 Pall Mall Rd.

19. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

Stab wounds of chest and neck

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1148 N. Carrollton Avenue

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.) 9-9-72 ?

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy  
M.D.CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/10/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-13-72

24C. NAME OF CEMETERY or CREMATORY

Harver Mem. Pk.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 11 1972

25B. NAME OF REGISTRAR

Sydney F. Houston

25C. FUNERAL DIRECTOR V. Bailey ADDRESS

Kelson F.H. 1348 Calhoun St.

0-2-0

1900

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1918

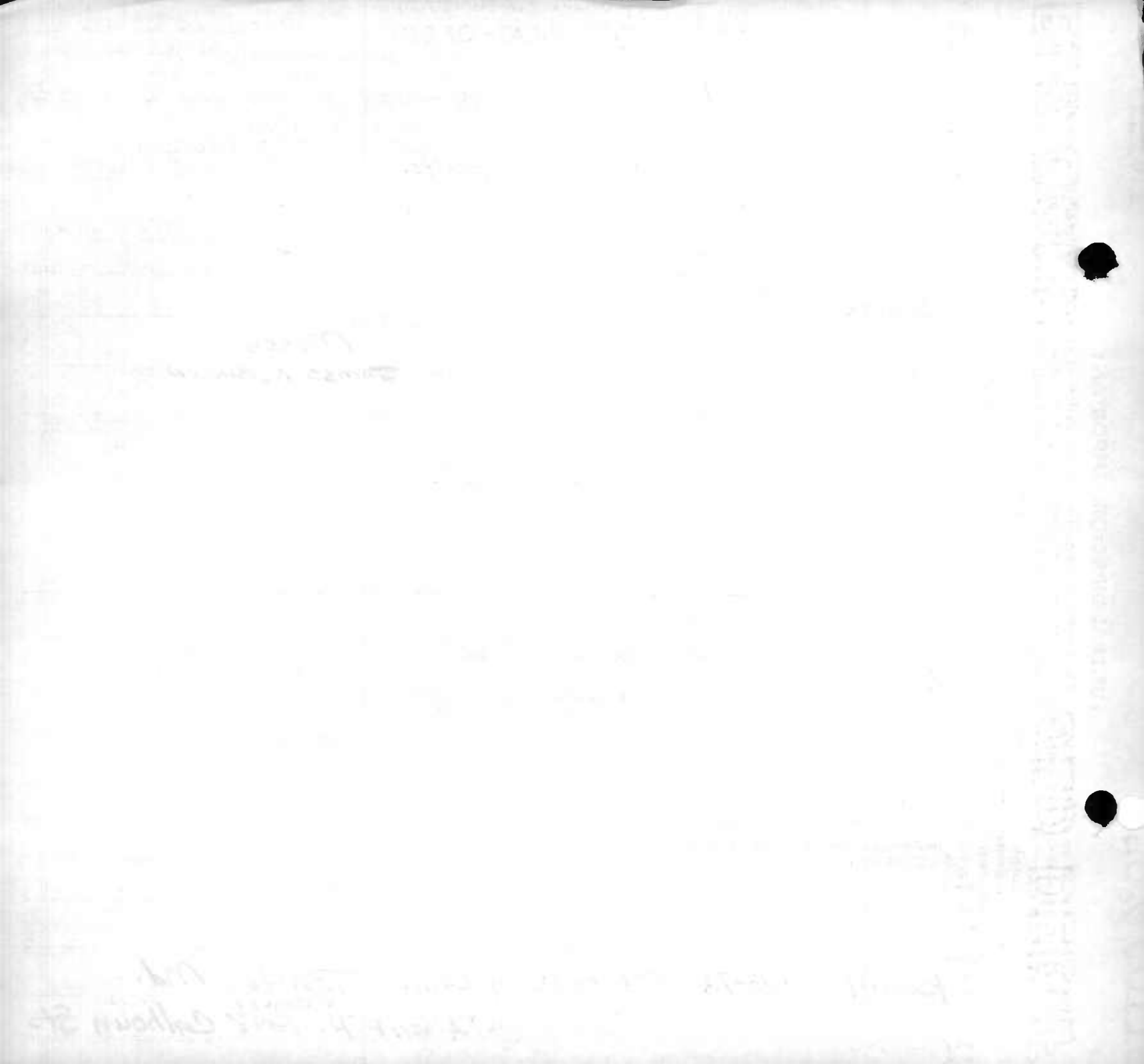
1919

1920

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                                                              |                                                                          |                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------|
| 72 08691                                                                                                                                                                                                                                                                                                                   |                         | BALTIMORE CITY HEALTH DEPT.                                                                                                                                 |                                                                                                                                                                              | REG. NO. 72 08691                                                        |                                                     |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                                              |                                                                          |                                                     |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                  |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Robinson, Julia</i>                                                                                               |                                                                                                                                                                              | 2. DATE AND HOUR OF DEATH<br><i>5:35pm 9-9-72</i>                        |                                                     |
| STATE OF MARYLAND - DEMO                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                              |                                                                          |                                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                        |                                                                          |                                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Sinai Hospital of Baltimore</i><br><i>Belvidere Ave at green spring 21215</i>                                                                                                                                                                                                   |                         |                                                                                                                                                             | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                          |                                                     |
| E. STREET AND NUMBER<br><i>1547 Leslie St. # 17</i>                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 1501                                                                                                                                                                         |                                                                          |                                                     |
| 5. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                    | 6. RACE<br><i>Black</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>1-27-60</i>                                                                                                                                           | 9. AGE (In years last birthday)<br><i>12 1/2 years</i>                   | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>STUDENT</i>                                                                                                                                                                                                              |                         |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore Maryland</i>                                                                                                       |                                                                          |                                                     |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 13. FATHER'S NAME<br><i>James Robinson</i>                                                                                                                                   |                                                                          |                                                     |
| 14. MOTHER'S MAIDEN NAME<br><i>Emma Moses</i>                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service                                                                       |                                                                          |                                                     |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 17. INFORMANT <i>JAMES ROBINSON</i> ADDRESS <i>pt chart Sinai Hospital</i>                                                                                                   |                                                                          |                                                     |
| 18. <i>013.91</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                                              |                                                                          |                                                     |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>Respiratory arrest</i>                                                                                                |                         |                                                                                                                                                             |                                                                                                                                                                              |                                                                          |                                                     |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>PTB meningitis or Encephalitis</i>                                                                                                                                                    |                         |                                                                                                                                                             |                                                                                                                                                                              |                                                                          |                                                     |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                                                              |                                                                          |                                                     |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                              | 20A. AUTOPSY? (Yes or No)                                                |                                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                      |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                                                                                                                                                                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                     |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                              |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                              | 21F. HOW DID INJURY OCCUR?                                               |                                                     |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-5-1972</i> to <i>9-9-1972</i> that (I) (we) last saw the deceased alive on <i>9-9-1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                                                              |                                                                          |                                                     |
| 23A. SIGNATURE<br><i>A. Shahideh M.D.</i>                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                                                              | 23B. DATE SIGNED<br><i>9-9-72</i>                                        |                                                     |
| 23C. PHYSICIAN'S NAME (Type)<br><i>ASADOLLAH - SHAHIDEH</i>                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                                                                                                                              | 23D. ADDRESS<br><i>Sinai Hospital of Baltimore</i>                       |                                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><i>9-13-72</i>                                                                                                                                 |                                                                                                                                                                              | 24C. NAME of CEMETERY or CREMATORY<br><i>Mt. Auburn Cem.</i>             |                                                     |
| 24D. LOCATION<br><i>Balto, Md.</i>                                                                                                                                                                                                                                                                                         |                         | 24E. DATE REC'D BY HEALTH DEPT.<br><i>SEP 11 1972</i>                                                                                                       |                                                                                                                                                                              | 24F. NAME OF REGISTRAR<br><i>James Robinson</i>                          |                                                     |
| 24G. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                            |                         | 24H. NAME OF REGISTRAR                                                                                                                                      |                                                                                                                                                                              | 24I. FUNERAL DIRECTOR V. BAILEY<br><i>Kalson F. H. 1348 Calhoun St</i>   |                                                     |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08692

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mack Keney  
MCKINLEY TAYLOR

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ 9 9 72 8:29 A.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL ADDRESS OR LOCATION) 11-29-72  
OR INSTITUTION LUTHERAN HOSPITAL (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour  
September 9, 1972 8:29 A.

CERTIFICATE AMENDED

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Virginia B. COUNTY V 43

6. SEX Male 7. RACE Negro 8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN Heathfiled D. INSIDE CITY LIMITS?  
YES ☐ NO ☐

9. DATE OF BIRTH 6-14-1914 10. AGE (In years last birthday) 58  
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER Rte. 2, Box 316

11. BIRTHPLACE (State or foreign country) Heathsville, Va  
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert Taylor

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired  
14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME Laura Taylor Curry

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 224-14-9384 18. INFORMANT ADDRESS  
Georgianna Lee 2660 Harlem Ave.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 19. 571.8 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). | CAUSE OF DEATH<br>Fatty metamorphosis of liver<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)  
yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  
2660 Harlem Ave.  
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE Ronald N. Kornblum Deputy CHIEF MEDICAL EXAMINER ☒  
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 9/9/72

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9-13-72 24C. NAME OF CEMETERY or CREMATORY Va. Home Land Fam. Lot Heathsville Va. 24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. SEP 11 1972 25B. NAME OF REGISTRAR Sidney H. Houston 25C. FUNERAL DIRECTOR V. R. Bailey ADDRESS Kelson Funeral Home 1348 N. Calhoun

Heathsville, Va.

11-29-1972 - Correction Form from Funeral Director - Vernon R. Bailey, Balto., Md. and  
Birth Certificate of Deceased - Mack Keney Taylor - Certificate #24442  
Bureau of Vital Statistics, Virginia Dept. of Health, Richmond, Va.  
born June 14, 1914. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-4601

72 08693

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 08693  
STATE OF MARYLAND-DHMH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                            |                                                                                                                                    |                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>John Miller</i>                                                                                                   |                                            | 2. DATE AND HOUR OF DEATH<br><i>9-5-72</i>   <i>3 45</i> A. M.                                                                     |                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                            | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>md.</i> B. COUNTY <i>2552</i> |                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Lutheran Hospital of Md.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                            | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                            | E. STREET AND NUMBER<br><i>1501 Dukeland ST.</i>                                                                                   |                                                          |
| 5. SEX<br><i>male</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br><i>Negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><i>10-15-14</i>        | 9. AGE (in years last birthday)<br><i>57 yrs</i>                                                                                   | If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>DISABLED</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>-</i>                                                                                                               |                                            | 11. BIRTHPLACE (State or foreign country)<br><i>AAITAX VA.</i>                                                                     |                                                          |
| 13. FATHER'S NAME<br><i>STEVEN MILLE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |                                                                                                                                    |                                                          |
| 14. MOTHER'S MAIDEN NAME<br><i>MARY HOLT</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                            |                                                                                                                                    |                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 16. SOCIAL SECURITY NO.<br><i>218-07-6647NA</i>                                                                                                             |                                            | 17. INFORMANT<br><i>ChaeT MARY ROBINSON</i> ADDRESS<br><i>3006 SEASON AVE</i>                                                      |                                                          |
| 18. CAUSE OF DEATH<br><i>250.91</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>URAE MIA</i><br><i>DIABETES MELLITUS</i><br><i>Atherosclerotic Heart Disease</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><i>-</i> |                         |                                                                                                                                                             |                                            |                                                                                                                                    |                                                          |
| 19A. DATE OF OPERATION<br><i>9-5-72</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>-</i>                                                                                                |                                            | 20A. AUTOPSY? (Yes or No)<br><i>YES</i>                                                                                            |                                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                           |                                                          |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><i>-</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>                                                 |                                            | 21F. HOW DID INJURY OCCUR?<br><i>-</i>                                                                                             |                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/3/72</i> to <i>9/5/72</i> that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                            |                                                                                                                                    |                                                          |
| 23A. SIGNATURE<br><i>Gandies</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                            | 23B. DATE SIGNED<br><i>9/5/72</i>                                                                                                  |                                                          |
| 23C. PHYSICIAN'S NAME (Type)<br><i>E. SANDOZ M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                            | 23D. ADDRESS<br><i>-</i>                                                                                                           |                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 24B. DATE<br><i>9-9-72</i>                                                                                                                                  |                                            | 24C. NAME of CEMETERY or CREMATORY<br><i>MT. Auburn</i>                                                                            |                                                          |
| 24D. LOCATION (City, town, or county) (State)<br><i>Westport Baltimore Md.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                            |                                                                                                                                    |                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 11 1972</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 25B. NAME OF REGISTRAR<br><i>Dr. J. Robinson</i>                                                                                                            |                                            | 25C. FUNERAL DIRECTOR<br><i>W. J. Brown</i> ADDRESS<br><i>1922 Edmonstone Ave</i>                                                  |                                                          |

7/26/72

3006 Seamon Ave.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                                                                                                            |                                                                                       |                                                           |                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| 7-500                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 72 08694                                                                                                                                                    |                                                                                                                            | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                                                           | 72 08694                                                                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |                                                                                                                            | STATE OF MARYLAND - DEATH                                                             |                                                           |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>George R. Finney</u>                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |                                                                                                                            | 2. DATE AND HOUR OF DEATH<br><u>9/9/72</u> <u>7:50</u> P.M.                           |                                                           |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                                                                                                            | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                                                           |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Bon Secours Hospital</u><br><u>Balto. &amp; Pulaski Sts.</u>                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |                                                                                                                            | A. STATE <u>Maryland</u><br>B. COUNTY <u>1603</u>                                     |                                                           |                                                                                               |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                                                                                                            | C. CITY OR TOWN<br><u>Baltimore</u>                                                   |                                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                                                                                                            | E. STREET AND NUMBER<br><u>1610 W. FRANKLIN ST.</u>                                   |                                                           |                                                                                               |  |
| 5. SEX<br><u>MALE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. RACE<br><u>B</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12/26/89</u>                                                                                        | 9. AGE (in years last birthday)<br><u>82 yrs.</u>                                     | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |                                                                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>unemployed</u>                                                                                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>                                                                              |                                                                                       |                                                           | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>                                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             | 13. FATHER'S NAME<br><u>George Finney</u>                                                                                  |                                                                                       |                                                           |                                                                                               |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Ida</u>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>unknown</u> |                                                                                       |                                                           |                                                                                               |  |
| 16. SOCIAL SECURITY NO.<br><u>231-07-2179</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><u>Almeda Finney 1610 W FRANKLIN ST</u>                                                           |                                                                                       |                                                           |                                                                                               |  |
| 18. CAUSE OF DEATH<br><u>410.9 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Pulmonary Edema</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Myocardial Infarction</u><br>3 days<br>(B) <u>—</u><br>(C) <u>—</u> |                     |                                                                                                                                                             |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>                         |                                                           |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                                                                                                            |                                                                                       |                                                           |                                                                                               |  |
| 19A. DATE OF OPERATION<br><u>9-9-72</u>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>—</u>                                                                                                |                                                                                                                            | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>                                               |                                                           | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>Yes</u>            |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                            |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>—</u>                                                        |                                                                                                                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><u>—</u>  |                                                           |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><u>—</u>                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                            | 21F. HOW DID INJURY OCCUR?<br><u>—</u>                                                |                                                           |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-1-72</u> 19 to <u>9-9-72</u> 19 that (I) (we) last saw the deceased alive on <u>9-9-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>9-9-72 7:50 PM</u>                                                                                                                          |                     |                                                                                                                                                             |                                                                                                                            |                                                                                       |                                                           |                                                                                               |  |
| 23A. SIGNATURE<br><u>Felimon A. Sonia MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |                                                                                                                            | 23B. DATE SIGNED<br><u>9-9-72</u>                                                     |                                                           | 23C. PHYSICIAN'S NAME (Type)<br><u>FELIMON A. SONIA MD</u>                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                    |                     | 24B. DATE<br><u>9-13-72</u>                                                                                                                                 |                                                                                                                            | 24C. NAME of CEMETERY or CREMATORY<br><u>MD NATIONAL PK</u>                           |                                                           | 24D. LOCATION (City, town, or county) (Plot)<br><u>Laurel - 113</u>                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 11 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 25B. NAME OF REGISTRAR<br><u>—</u>                                                                                                                          |                                                                                                                            | 25C. FUNERAL DIRECTOR<br><u>—</u>                                                     |                                                           | ADDRESS<br><u>—</u>                                                                           |  |



72 08695 **STATE OF MARYLAND-DEATH** 72 08695

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **LARRY WHITEHEAD**

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ M.

3. DATE PRONOUNCED DEAD Month Day Year Hour  
**September 9, 1972 4:29 P. M.**

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
**BON SECOURS HOSPITAL (DOA)**

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY **2004**

6. SEX **Male** 7. RACE **Negro** 8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN **Baltimore** D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH **MAY 1-1954** 10. AGE (In years last birthday) **18** 11. BIRTHPLACE (State or foreign country) **BALTIMORE MD** 12. CITIZEN OF WHAT COUNTRY? **USA** 13. FATHER'S NAME **WILLIE MCGEE**

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **LABORER** 14B. KIND OF BUSINESS OR INDUSTRY **LABORER** 15. MOTHER'S MAIDEN NAME **ROSALIE PHILLIPS**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 17. SOCIAL SECURITY NO. **ROSALIE WHITEHEAD 2237 W. BALTO** 18. INFORMANT ADDRESS **ROSALIE WHITEHEAD 2237 W. BALTO**

19. CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**E966X Stab wound of chest**  
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  
(B) DUE TO, OR AS A CONSEQUENCE OF:  
(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION **2** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED **2004** 21. AUTOPSY? (Yes or No) **yes**

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Street** 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **2204 Booth Street** 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) **9-9-72 4:00 P. m.** 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? **Stabbed during altercation**

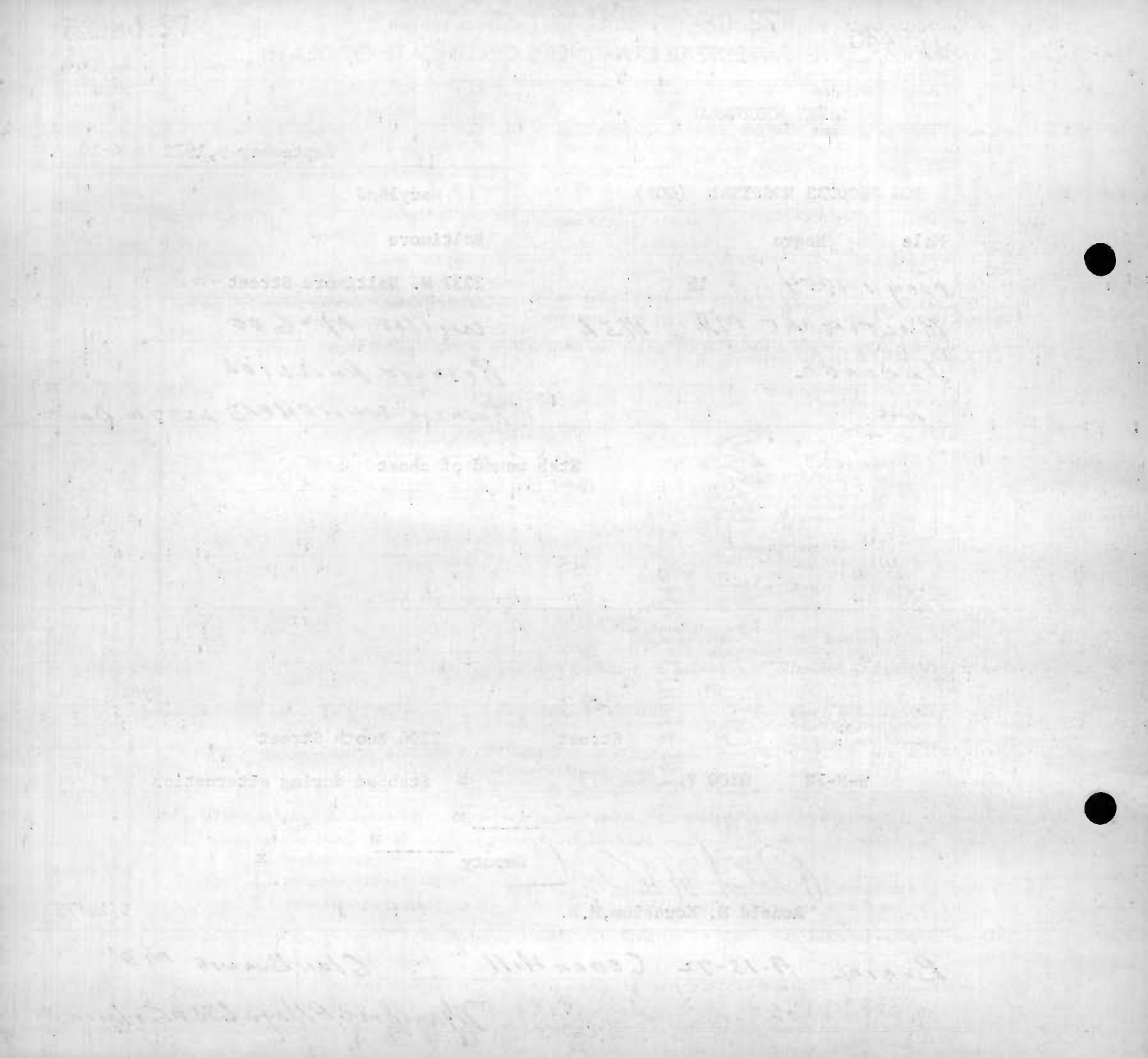
23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum, M.D.** Deputy CHIEF MEDICAL EXAMINER ☒ DATE SIGNED **9/10/72**  
EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.** ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) **BURIAL** 24B. DATE **9-13-72** 24C. NAME OF CEMETERY or CREMATORY **CEDAR HILL** 24D. LOCATION (City, town, or county) (State) **GLEN BURNIE MD**

25A. DATE REC'D BY HEALTH DEPT. **SEP 11 1972** 25B. NAME OF REGISTRAR **Adm. Registrar** 25C. FUNERAL DIRECTOR ADDRESS **Managers PH 638 N. G. 1st St**

VS 151-REV. 1/1/68



M.

M.

No ☐

583 g. / mm 5



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

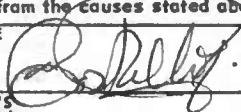
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                                                                                                                                                                                           |                                 | REG. NO. 72 08697                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------|
| <b>R-300</b><br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                 |                  | STATE OF MARYLAND - DEATH                                                                                                                                                                                                                                                                                                 |                                 |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) <b>REED, ROBERT</b>                                                                                                                                                                                                                                                                                                |                  | 2. DATE AND HOUR OF DEATH<br><b>9/9/72 4-15 PM</b>                                                                                                                                                                                                                                                                        |                                 |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>LUTHERAN Hospital of MD Inc</b><br><b>6730 Ashburton ST</b>                                                                                                                 |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>1605</b><br><br>C. CITY OR TOWN <b>BALTIMORE, MD</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>641 N. BENTLEY ST</b> |                                 |                                                                          |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                           | 6. RACE <b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                               | 8. DATE OF BIRTH <b>5-22-94</b> | 9. AGE (in years last birthday) <b>78</b>                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret Laborer</b>                                                                                                                                                                                                                                         |                  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>                                                                                                                                                                                                                                                                            |                                 |                                                                          |
| 11. BIRTHPLACE (State or foreign country)<br><b>S. CAR - CHESTER</b>                                                                                                                                                                                                                                                                                      |                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                                                                                                                                                                                              |                                 |                                                                          |
| 13. FATHER'S NAME<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                       |                  | 14. MOTHER'S MAIDEN NAME<br><b>Nancy</b>                                                                                                                                                                                                                                                                                  |                                 |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                     |                  | 16. SOCIAL SECURITY NO. <b>030-06-2506</b>                                                                                                                                                                                                                                                                                |                                 |                                                                          |
| 17. INFORMANT<br><b>WIFE, MARGARET</b>                                                                                                                                                                                                                                                                                                                    |                  | ADDRESS <b>SAME</b>                                                                                                                                                                                                                                                                                                       |                                 |                                                                          |
| 18. <b>486X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Pulmonary Embolism.</b><br><br>(B) <b>Cerebrovascular Accident.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Pneumonia @ upper lobe.</b><br><b>- Bilateral Atelectasis Pneumonia</b>                                                      |                                 |                                                                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                    |                  |                                                                                                                                                                                                                                                                                                                           |                                 |                                                                          |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                                           |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                          |                                 | 20A. AUTOPSY? <b>NO</b> or No?                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                            |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                  |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                 |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                    |                                 | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7/12/72</b> 19 <b>72</b> to <b>9/9/72</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                            |                  |                                                                                                                                                                                                                                                                                                                           |                                 |                                                                          |
| 23A. SIGNATURE<br><b>E. SANDOZ, M.D.</b>                                                                                                                                                                                                                                                                                                                  |                  | 23B. DATE SIGNED<br><b>9/9/72</b>                                                                                                                                                                                                                                                                                         |                                 | 23C. PHYSICIAN'S NAME (Type)<br><b>E. SANDOZ, M.D.</b>                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Buried</b>                                                                                                                                                                                                                                                                                                 |                  | 24B. DATE<br><b>9-15-72</b>                                                                                                                                                                                                                                                                                               |                                 | 24C. NAME OF CEMETERY OR CREMATORY<br><b>MT AUBURN</b>                   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                         |                  | 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 11 1972</b>                                                                                                                                                                                                                                                                        |                                 |                                                                          |
| 25B. NAME OF REGISTRAR<br><b>Audrey Johnston</b>                                                                                                                                                                                                                                                                                                          |                  | 25C. FUNERAL DIRECTOR<br><b>Wm. Sam'l Hughes</b>                                                                                                                                                                                                                                                                          |                                 |                                                                          |
| ADDRESS <b>635 N. 9th St</b>                                                                                                                                                                                                                                                                                                                              |                  | ADDRESS                                                                                                                                                                                                                                                                                                                   |                                 |                                                                          |

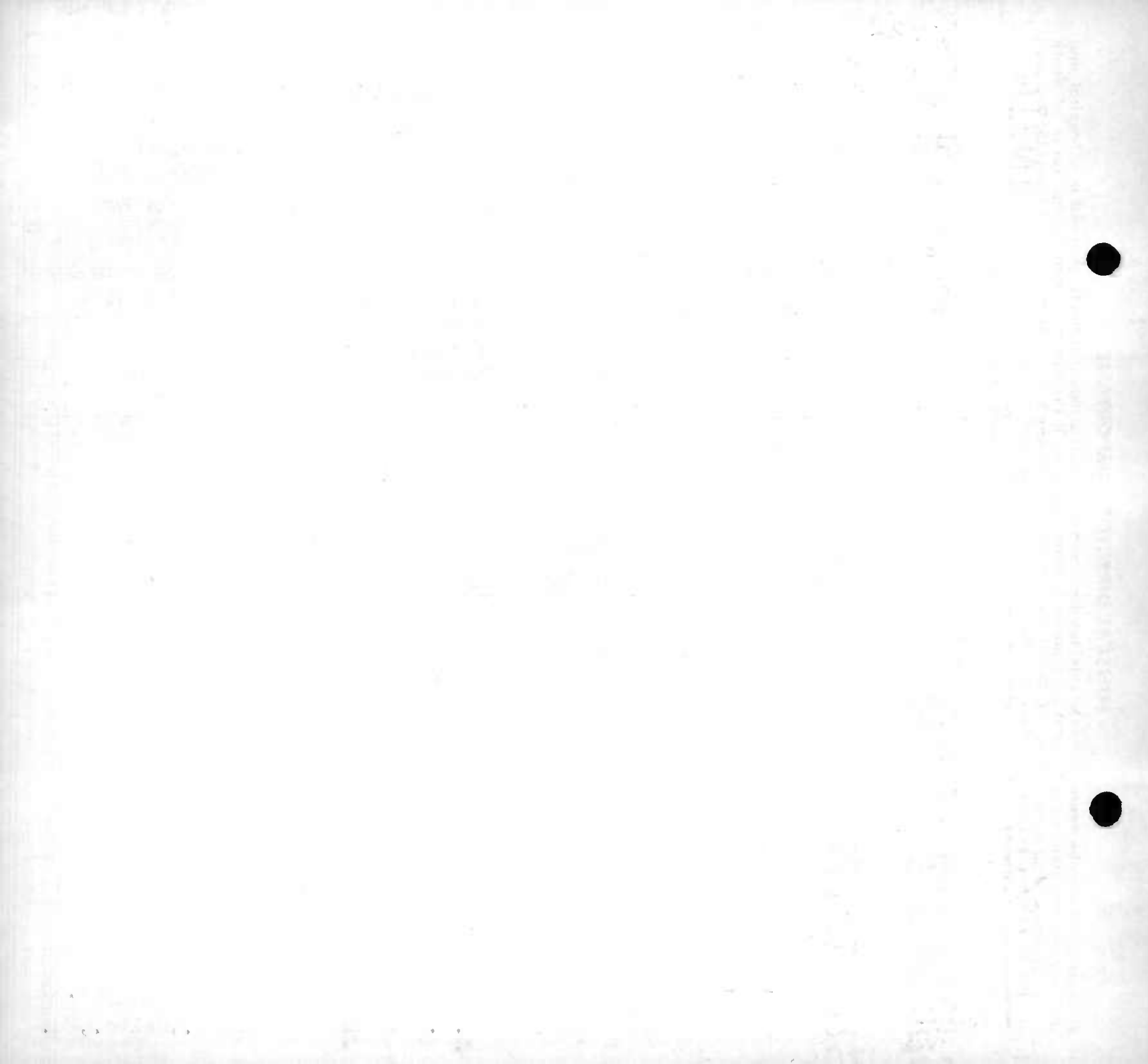




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

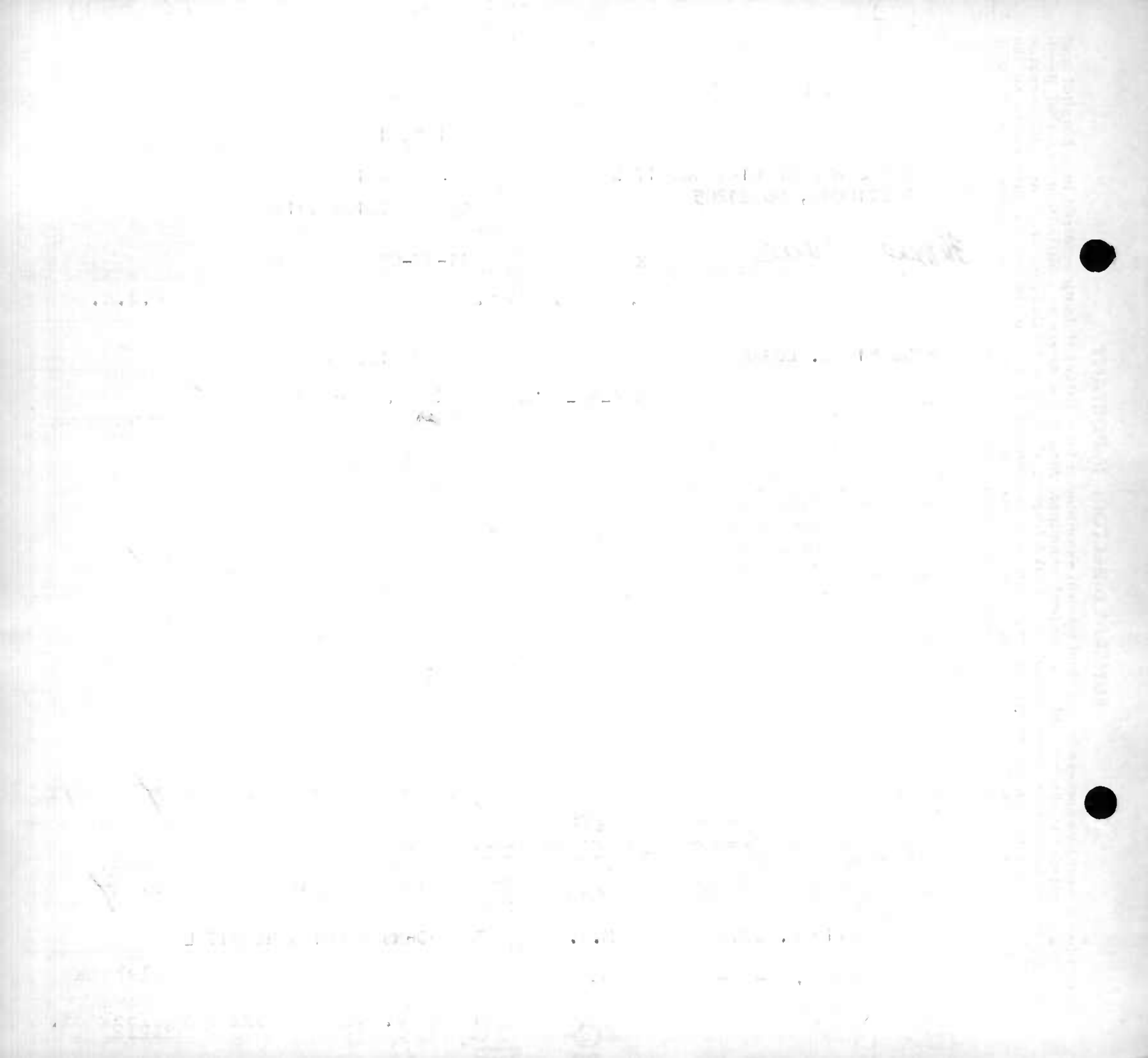
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                                                                            | REG. NO. 72 08698                                                          |                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| K-452                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                                                                                            | 72 08698                                                                   |                                                                                                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                                                                                            | STATE OF MARYLAND-DEMH                                                     |                                                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>KLINGSTINE, ROSELLA B.</b>                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>September 8 1972 18.20 p.m.</b>                                                                                                                                            |                                                                            |                                                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1202</b>                                                                  |                                                                            |                                                                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>THE UNION MEMORIAL HOSPITAL.</b><br><b>44</b>                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                                                        |                                                                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             | E. STREET AND NUMBER<br><b>1 EAST UNIVERSITY PARKWAY APT 1101 BALTO. MD 21218</b>                                                                                                                          |                                                                            |                                                                                                             |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                          | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-5-1884</b>                                                                                                                                                                        | 9. AGE (In years last birthday)<br><b>88</b>                               | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min.                                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED-HOMEMAKER</b>                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                               |                                                                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                               |
| 13. FATHER'S NAME<br><b>BUCK, CHARLES H.</b>                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>ROBINSON, ROSELLA</b>                                                                                                                                                       |                                                                            |                                                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                            |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>215-09-6035</b>                                                                                                                                                              |                                                                            | 17. INFORMANT<br><b>RATIGAN, Lily B. Mrs. JOHN A.</b><br>ADDRESS: <b>614 Tunbridge Road BALTO. MD 21212</b> |
| 18. <b>436.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b>                                                                                                      |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                               |                                                                            |                                                                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                   |                         |                                                                                                                                                             | (A) IMMEDIATE CAUSE <b>Cardiorespiratory Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Cerebrovascular accident.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Arteriosclerosis Disease.</b> |                                                                            |                                                                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Prob. Pulmonary embolism.</b>                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                                                                            |                                                                            |                                                                                                             |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                               |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                            | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                     |                                                                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                                                                                                                                                                                                            | 21C. WHERE DID INJURY OCCUR<br>(If in Baltimore City, give exact location) |                                                                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                     |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                            | 21F. HOW DID INJURY OCCUR                                                  |                                                                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>August 27 1972</b> to <b>September 8 1972</b> that (I) (we) last saw the deceased alive on <b>September 8 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                                                                                            |                                                                            |                                                                                                             |
| 23A. SIGNATURE<br>                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                                                                                            | 23B. DATE SIGNED<br><b>September 8 1972.</b>                               |                                                                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CASTILLO WALTER N.</b>                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                                                                                            | 23D. ADDRESS<br><b>201-E, 33rd Street Balto. MD 21218</b>                  |                                                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                        |                         | 24B. DATE<br><b>9-11-72</b>                                                                                                                                 |                                                                                                                                                                                                            | 24C. NAME of CEMETERY or CREMATORY<br><b>Woodlawn</b>                      |                                                                                                             |
| 24D. LOCATION<br><b>Woodlawn</b>                                                                                                                                                                                                                                                                                                                 |                         | 24E. STATE<br><b>Md.</b>                                                                                                                                    |                                                                                                                                                                                                            | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                      |                                                                                                             |
| 25B. NAME OF REGISTRAR<br><b>Edgar Johnson</b>                                                                                                                                                                                                                                                                                                   |                         | 25C. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>                                                                                    |                                                                                                                                                                                                            |                                                                            |                                                                                                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                       |  | 72 08699 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------|
| <b>B-650</b><br>BIRTH NO.<br>1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                     |  | <b>72-8699</b><br>CERTIFICATE OF DEATH                                                                                                                                                                                |  |          |
| 2. DATE AND HOUR OF DEATH<br><b>Sept 9, 1972</b>                                                                                                                                                                                                                                                                                        |  | REG. NO.<br><b>STATE OF MARYLAND-DHMH</b>                                                                                                                                                                             |  |          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>LAURA BROWN</b>                                                                                                                                                                                                                                                            |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br><b>VIRGINIA</b><br>B. COUNTY<br><b>ALEXANDRIA</b>                                                                |  |          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL</b><br><b>BALTIMORE, MD 21205</b>                                                                                                                                                                                                                                 |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                    |  |          |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                 |  | 6. RACE<br><b>Cauc.</b>                                                                                                                                                                                               |  |          |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                             |  | 8. DATE OF BIRTH<br><b>11-23-05</b>                                                                                                                                                                                   |  |          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary</b>                                                                                                                                                                                                                         |  | 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>                                                                                                                                                           |  |          |
| 13. FATHER'S NAME<br><b>BENJAMIN C. LOGAN</b>                                                                                                                                                                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><b>DRUCILLA JONES</b>                                                                                                                                                                     |  |          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                   |  | 16. SOCIAL SECURITY NO.<br><b>426-30-2584</b>                                                                                                                                                                         |  |          |
| 17. INFORMANT<br><b>Hosp. Records</b>                                                                                                                                                                                                                                                                                                   |  | ADDRESS                                                                                                                                                                                                               |  |          |
| <b>18. 410.9 I + 183.0</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                       |  |          |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><b>pulmonary edema</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>atherosclerotic heart disease</b> |  |          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>II</b><br><b>Adenocarcinoma of ovary.</b>                                                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                          |  |          |
| 19A. DATE OF OPERATION<br><b>Sept 8</b>                                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Colonic obstruction</b>                                                                                                                                        |  |          |
| 20A. AUTOPSY (Yes or No)<br><b>No</b>                                                                                                                                                                                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                  |  |          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>INJURY OCCUR?</b>                                                                                                      |  |          |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><b>Sept 7 1972</b>                                                                                                                                                                                                                                                         |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                                                                                  |  |          |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Sept 7 1972</b> to <b>Sept 9 1972</b> and that (I) (we) last saw the deceased alive on <b>Sept 10 1972</b> and that in (my) (our) opinion death occurred on the date one hour and from the causes stated above. (I) (We) (did not) view the body after death.      |  | 23A. SIGNATURE<br><b>David K. Bone M.D.</b>                                                                                                                                                                           |  |          |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DAVID K. BONE</b>                                                                                                                                                                                                                                                                                    |  | 23D. ADDRESS<br><b>M.D. THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                |  |          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Removal-Bur.</b>                                                                                                                                                                                                                                                                         |  | 24B. DATE<br><b>9-12-72</b>                                                                                                                                                                                           |  |          |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Gulin, Cemetery</b>                                                                                                                                                                                                                                                                            |  | 24D. LOCATION (City, town, or county) (State)<br><b>Gulin Alabama</b>                                                                                                                                                 |  |          |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR<br><b>Henry W. Jenkins &amp; Sons</b>                                                                                                                                                          |  |          |
| 25C. FUNERAL DIRECTOR<br><b>4905 York Rd.</b>                                                                                                                                                                                                                                                                                           |  | ADDRESS<br><b>21212</b>                                                                                                                                                                                               |  |          |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

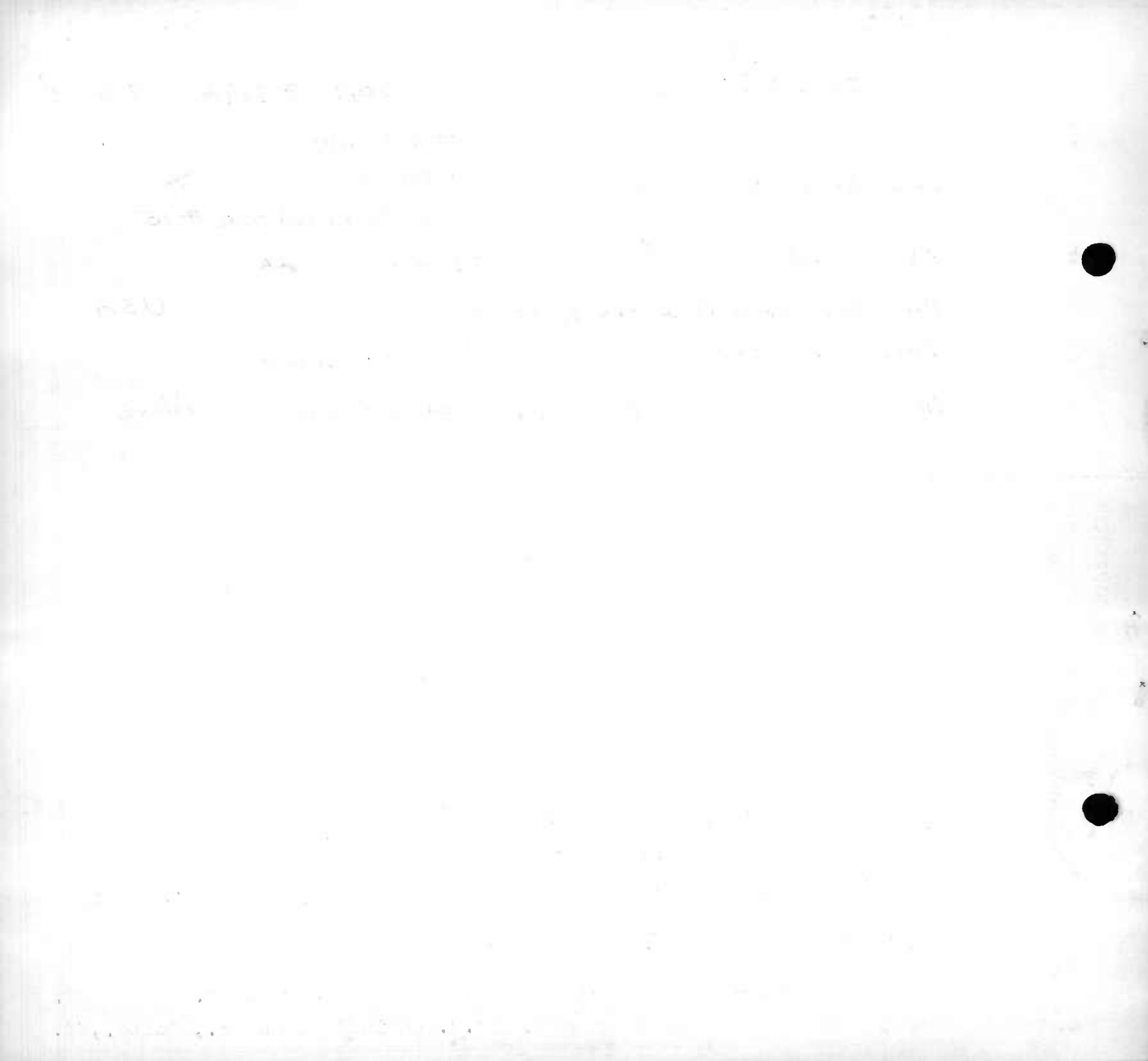
| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                                                  |           |                                                                                                                                                                               |                            | REG. NO. 72 08780                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------|
| B-650 72 08700                                                                                                                                                                                                                                                                                                                                                                    |           |                                                                                                                                                                               |                            | STATE OF MARYLAND-DHMH                                                            |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                            |           | 2. DATE AND HOUR OF DEATH                                                                                                                                                     |                            |                                                                                   |
| Frank F. Beirne                                                                                                                                                                                                                                                                                                                                                                   |           | September 8, 1972 7:00 A.M.                                                                                                                                                   |                            |                                                                                   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                            |           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                         |                            |                                                                                   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>90 4713 Keswick Rd.                                                                                                                                                                                                                                                                                                                   |           | A. STATE Md.<br>C. CITY OR TOWN Balto.<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 4401 Roland Ave. |                            |                                                                                   |
| 5. SEX M                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                   | 8. DATE OF BIRTH 8-20-1890 | 9. AGE (In years lost birthday) 82                                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Journalist                                                                                                                                                                                                                                                                         |           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Newspaper                                                                                                                                |                            | 11. BIRTHPLACE (State or foreign country)<br>Va.                                  |
| 13. FATHER'S NAME<br>Richard F. Beirne                                                                                                                                                                                                                                                                                                                                            |           | 14. MOTHER'S MAIDEN NAME<br>Clara Grundy                                                                                                                                      |                            |                                                                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes WW 1                                                                                                                                                                                                                                                              |           | 16. SOCIAL SECURITY NO.<br>213-03-2580A                                                                                                                                       |                            | 17. INFORMANT ADDRESS<br>D. Randall Beirne 4713 Keswick Rd.                       |
| 18. 195.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                         |           |                                                                                                                                                                               |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 mos<br>6 mos                    |
| <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary insufficiency from pulmonary fibrosis related to</p> <p>(B) Squamous cell ca of ear 2 weeks prior 1 1/2 yrs DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) post irradiation Rx</p>                                                                                                             |           |                                                                                                                                                                               |                            |                                                                                   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                               |           |                                                                                                                                                                               |                            |                                                                                   |
| 19A. DATE OF OPERATION 0 -                                                                                                                                                                                                                                                                                                                                                        |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -                                                                                                                            |                            | 20A. AUTOPSY? (Yes or No) no                                                      |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) -                                                                                                                                                                                                                                         |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -                                                                                    |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -        |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -                                                                                                                                                                                                                                                                                                                       |           | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                     |                            | 21F. HOW DID INJURY OCCUR? -                                                      |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from November 19 67 to present 9/8 19 72, that (I) ( <del>we</del> ) last saw the deceased alive on 9/6 19 72 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |           |                                                                                                                                                                               |                            |                                                                                   |
| 23A. SIGNATURE<br>John Mulholland M.D.                                                                                                                                                                                                                                                                                                                                            |           |                                                                                                                                                                               |                            | 23B. DATE SIGNED<br>9/8/72                                                        |
| 23C. PHYSICIAN'S NAME (Type)<br>John Mulholland M.D.                                                                                                                                                                                                                                                                                                                              |           |                                                                                                                                                                               |                            | 23D. ADDRESS<br>Union Memorial Hospital, Balto., Md.                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                |           | 24B. DATE<br>9-11-72                                                                                                                                                          |                            | 24C. NAME of CEMETERY or CREMATORY<br>Druid Ridge                                 |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                                                                    |           | 25B. NAME OF REGISTRAR<br>Sidney W. Jenkins                                                                                                                                   |                            | 25C. FUNERAL DIRECTOR<br>Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212 |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 72 08701                                                                                                                                                                                                                                                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| P-362                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 72 08701                                                                                                                                                                                                                                                                                                |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | REG. NO.                                                                                                                                                                                                                                                                                                |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                                                                                               |  |
| Elwood Peterson                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | Sept. 8, 1972 7:00 P.M.                                                                                                                                                                                                                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                                                                                                   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                 |  |  |  | A. STATE B. COUNTY                                                                                                                                                                                                                                                                                      |  |
| Sinai Hospital                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 3 Md 2719                                                                                                                                                                                                                                                                                               |  |
| 5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                   |  |  |  | 8. DATE OF BIRTH 9. AGE (In years lost birthday) 10. BIRTHPLACE (State or foreign country) 11. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                 |  |
| M W                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  | 09-10-7 65 Minnesota USA                                                                                                                                                                                                                                                                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                             |  |  |  | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                  |  |
| Mfg. Represent. Household Supplies                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | Minnesota USA                                                                                                                                                                                                                                                                                           |  |
| 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service                                                                                                                                                                                                  |  |
| Peter Peterson                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | Hannah Nelson                                                                                                                                                                                                                                                                                           |  |
| 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  | 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                      |  |
| 470-03-1696 G. Jean Peterson Above                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                         |  |
| 20. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                                          |  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                             |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                       |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                            |  |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                    |  |  |  | 1hr 3day weeks                                                                                                                                                                                                                                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? |  |  |  | 22. I certify that (I) (this hospital) attended the deceased from 8/17/72 19 to 9/8 1972 that (I) (we) last saw the deceased alive on 9/8 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |  |
| 23A. SIGNATURE 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | 24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                     |  |
| Michael Ference III, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | 9/8/72                                                                                                                                                                                                                                                                                                  |  |
| Michael Ference III                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  | 24 - E Wyndmoor Pl, Balt. 21207                                                                                                                                                                                                                                                                         |  |
| Burial 9-12-72 Lakeview Memorial                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | Carroll Co. Md.                                                                                                                                                                                                                                                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF FUNERAL DIRECTOR 25C. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                               |  |  |  | 26. NAME OF FUNERAL HOME 26C. FUNERAL HOME ADDRESS                                                                                                                                                                                                                                                      |  |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | H.W. Jenkins & Sons Co., Balto., Md.                                                                                                                                                                                                                                                                    |  |

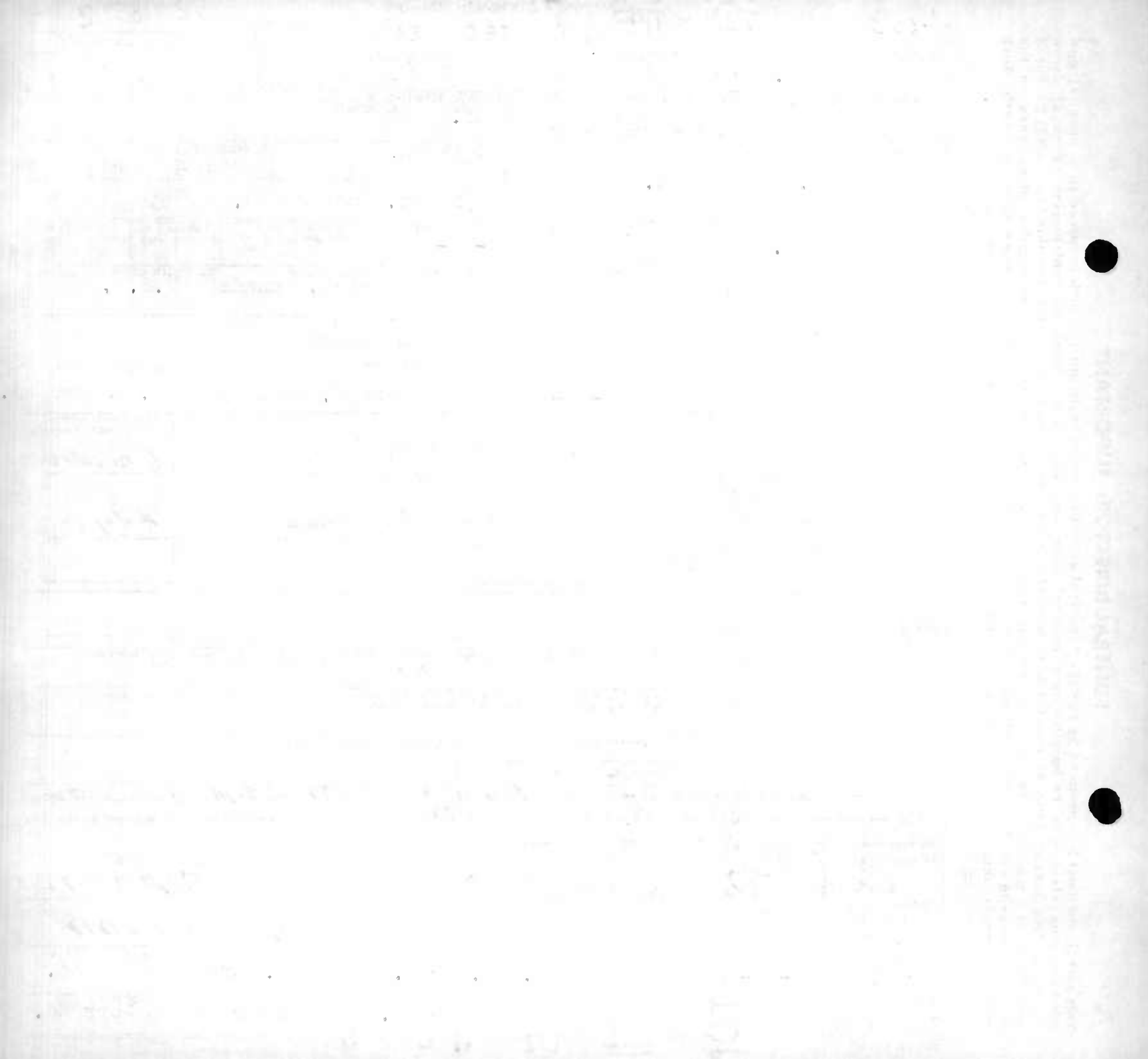




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| G-653 72 08702 BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | 72 08702                                                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | REG. NO.                                                                                                                                                                     |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                    |  |
| Mary G. Grant                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  | Sept. 9, 1972 12 <sup>05</sup> A.M.                                                                                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 4. USUAL RESIDENCE Where deceased lived, if institution; residence before admission                                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                      |  |                                                                                                        |  | A. STATE B. COUNTY                                                                                                                                                           |  |
| 00 328 St. Dunstan Rd.                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | Md.                                                                                                                                                                          |  |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                               |  | 6. RACE<br>Cauc.                                                                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                  |  |
| 8. DATE OF BIRTH<br>9-12-1891                                                                                                                                                                                                                                                                                                                  |  | 9. AGE (In years last birthday) 80                                                                     |  | 10. Under 1 Yr. 11. Under 24 Hrs. 12. Under 1 Mo. 13. Under 1 Day 14. Under 1 Hr. 15. Under 1 Min.                                                                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                    |  |                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                            |  |
| Housewife                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | Own Home                                                                                                                                                                     |  |
| 13. FATHER'S NAME<br>William Buswell                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 14. MOTHER'S MAIDEN NAME<br>Hannah O'Brien                                                                                                                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                 |  |                                                                                                        |  | 16. SOCIAL SECURITY NO.<br>212-01-8479B                                                                                                                                      |  |
| 17. INFORMANT<br>Robert J. Grant                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | ADDRESS<br>328 St. Dunstan Rd.                                                                                                                                               |  |
| 18. 153.21<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                                                                                                        |  | CAUSE OF DEATH<br>Carcinoma Descending Colon<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Hypostatic Pneumonia<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 months<br>4 days                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                                              |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                                              |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY (Yes or No)<br>No                                                                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                     |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 6 1972 to Sept. 9 1972 that (I) (we) last saw the deceased alive on Sept 8 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.                                     |  |                                                                                                        |  |                                                                                                                                                                              |  |
| 23A. SIGNATURE<br>Carl F. Benson MD                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 23B. DATE SIGNED<br>Sept 9, 1972                                                                                                                                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Carl F. Benson MD                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 23D. ADDRESS<br>5111 York Rd Balto Md 21212                                                                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                             |  | 24B. DATE<br>9-12-72                                                                                   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Dulaney Val. Mem. Gards.                                                                                                               |  |
| 24D. LOCATION (City, town, or county)<br>Balto. County                                                                                                                                                                                                                                                                                         |  | 24E. (State)<br>Md.                                                                                    |  |                                                                                                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR<br>Sidney Johnson                                                               |  | 25C. FUNERAL DIRECTOR<br>Henry W. Jenkins & Sons                                                                                                                             |  |
| 25D. ADDRESS<br>4905 York Rd.                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  |                                                                                                                                                                              |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                  |         |                                                                            |                                                                                                        | 72 08703                                                  |                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------|
| M-245 72 08703                                                                                                                                                                                                                                                                                                                                                    |         |                                                                            |                                                                                                        | REG. NO. 72 08703                                         |                                                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                         |         |                                                                            |                                                                                                        | STATE OF MARYLAND-DEMR                                    |                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                            |         |                                                                            | 2. DATE AND HOUR OF DEATH                                                                              |                                                           |                                                                          |
| Patrick J. McLain                                                                                                                                                                                                                                                                                                                                                 |         |                                                                            | Sept. 10, 1972 M.                                                                                      |                                                           |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                            |         |                                                                            | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                  |                                                           |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                         |         |                                                                            | A. STATE B. COUNTY                                                                                     |                                                           |                                                                          |
| 5601 Sinclair Lane Apt. B                                                                                                                                                                                                                                                                                                                                         |         |                                                                            | Maryland                                                                                               |                                                           |                                                                          |
| CERTIFICATE AMENDED                                                                                                                                                                                                                                                                                                                                               |         |                                                                            | C. CITY OR TOWN                                                                                        |                                                           | D. INSIDE CITY LIMITS?                                                   |
|                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                            | Baltimore                                                                                              |                                                           | YES <input checked="" type="checkbox"/> * NO <input type="checkbox"/>    |
| E. STREET AND NUMBER                                                                                                                                                                                                                                                                                                                                              |         |                                                                            | 5601 Sinclair Lane 21206                                                                               |                                                           |                                                                          |
| 5. SEX                                                                                                                                                                                                                                                                                                                                                            | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH                                                                                       | 9. AGE (In years last birthday)                           | 10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.               |
| M                                                                                                                                                                                                                                                                                                                                                                 | W       | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         | 10-25-1907                                                                                             | 64                                                        |                                                                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                       |         |                                                                            | 11. BIRTHPLACE (State or foreign country)                                                              |                                                           | 12. CITIZEN OF WHAT COUNTRY?                                             |
| Government Worker                                                                                                                                                                                                                                                                                                                                                 |         |                                                                            | Government                                                                                             |                                                           | Pennsylvania USA                                                         |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                 |         |                                                                            | 14. MOTHER'S MAIDEN NAME                                                                               |                                                           |                                                                          |
| Michael McLain                                                                                                                                                                                                                                                                                                                                                    |         |                                                                            | Mary Sullivan                                                                                          |                                                           |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                          |         |                                                                            | 16. SOCIAL SECURITY NO.                                                                                |                                                           | 17. INFORMANT ADDRESS                                                    |
| Yes WWII                                                                                                                                                                                                                                                                                                                                                          |         |                                                                            | 217-26-0760                                                                                            |                                                           | Mrs. Sara T. McLain Same                                                 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                |         |                                                                            | CAUSE OF DEATH                                                                                         |                                                           |                                                                          |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                      |         |                                                                            | Cerebral Vascular Accident                                                                             |                                                           |                                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                 |         |                                                                            | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                    |                                                           |                                                                          |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                         |         |                                                                            | ASCVD & severe myocardial ischemia                                                                     |                                                           |                                                                          |
| II                                                                                                                                                                                                                                                                                                                                                                |         |                                                                            | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                    |                                                           |                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                  |         |                                                                            | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                    |                                                           |                                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |         |                                                                            | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                           | 20A. AUTOPSY? (Yes or No)                                                |
|                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                            |                                                                                                        |                                                           | No                                                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                             |         |                                                                            | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                           | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                            |                                                                                                        |                                                           |                                                                          |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                         |         |                                                                            | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                           | 21F. HOW DID INJURY OCCUR?                                               |
|                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                            |                                                                                                        |                                                           |                                                                          |
| 22. I certify that (I) <del>(this hospital)</del> attended the deceased from June 1956 to May 1972, that (I) <del>(we)</del> last saw the deceased alive on 13 May 1972 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> (did not) view the body after death. |         |                                                                            |                                                                                                        |                                                           |                                                                          |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                    |         |                                                                            |                                                                                                        | 23B. DATE SIGNED                                          |                                                                          |
| Wm. H. Kammer, Jr.                                                                                                                                                                                                                                                                                                                                                |         |                                                                            |                                                                                                        | 11 Sept. 1972                                             |                                                                          |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                      |         |                                                                            |                                                                                                        | 23D. ADDRESS                                              |                                                                          |
| William H. Kammer, Jr.                                                                                                                                                                                                                                                                                                                                            |         |                                                                            |                                                                                                        | 6011 York Road Balto., Md. 21212                          |                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                          |         | 24B. DATE                                                                  |                                                                                                        | 24C. NAME OF CEMETERY or CREMATORY                        |                                                                          |
| Burial                                                                                                                                                                                                                                                                                                                                                            |         | 9-13-72                                                                    |                                                                                                        | Holy Redeemer                                             |                                                                          |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                     |         | 24E. NAME OF REGISTRAR                                                     |                                                                                                        | 24F. FUNERAL DIRECTOR ADDRESS                             |                                                                          |
| Balto. Md.                                                                                                                                                                                                                                                                                                                                                        |         | Dorothy H. Hinton                                                          |                                                                                                        | H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 |                                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                   |         | 25B. NAME OF REGISTRAR                                                     |                                                                                                        | 25C. FUNERAL DIRECTOR ADDRESS                             |                                                                          |
| SEP 11 1972                                                                                                                                                                                                                                                                                                                                                       |         | Dorothy H. Hinton                                                          |                                                                                                        | H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 |                                                                          |

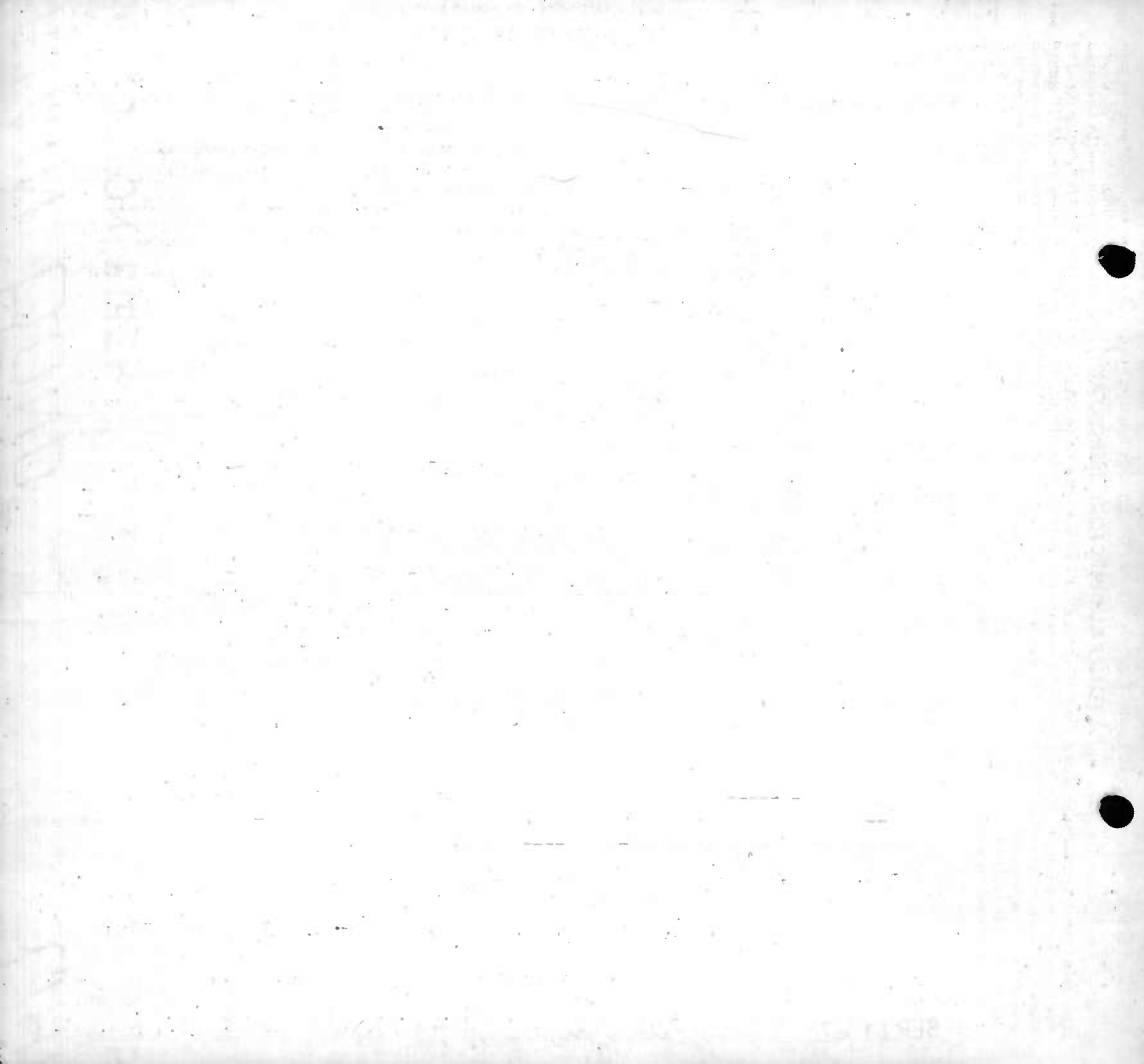
9-15-1972 - Correction Form from Funeral Director-Henry W. Jenkins & Sons Co., Balto., Md.

HRS

# FUNERAL DIRECTOR: IMPORTANT


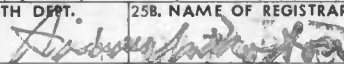

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                                                                                                                                                           |  | REG. NO. <span style="float: right;">72 08704</span>                               |                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|---------------------------------------|
| G-635                                                                                                                                                                                                                                                                                                                            |              | 72 08704                                                                                                                                                                                                                                                                                                                  |  | CERTIFICATE OF DEATH                                                               |                                       |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                        |              | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                    |  | 2. DATE AND HOUR OF DEATH                                                          |                                       |
|                                                                                                                                                                                                                                                                                                                                  |              | Sadie M. Gardner                                                                                                                                                                                                                                                                                                          |  | Sept. 10, 1972 4:45 P. M.                                                          |                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                           |              | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                                                                                                                                                                                                                     |  |                                                                                    |                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>90 Gould Convalesarium                                                                                                                                                                                                                                                               |              | A. STATE<br>Maryland                                                                                                                                                                                                                                                                                                      |  |                                                                                    |                                       |
|                                                                                                                                                                                                                                                                                                                                  |              | B. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                                    |  | C. CITY OR TOWN<br>Baltimore                                                       |                                       |
|                                                                                                                                                                                                                                                                                                                                  |              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                             |  |                                                                                    |                                       |
|                                                                                                                                                                                                                                                                                                                                  |              | E. STREET AND NUMBER<br>5222 Crowson Avenue                                                                                                                                                                                                                                                                               |  | 21212                                                                              |                                       |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                      | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                               |  | 8. DATE OF BIRTH<br>6-9-1897                                                       | 9. AGE (In years last birthday)<br>75 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                                         |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                                                                                                                                                                                                                             |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                   |                                       |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                              |              | 13. FATHER'S NAME<br>John Feige                                                                                                                                                                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br>Mary Nolte                                             |                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                   |              | 16. SOCIAL SECURITY NO.<br>217-01-2351                                                                                                                                                                                                                                                                                    |  | 17. INFORMANT<br>Miss Augusta D. Gardner                                           |                                       |
|                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br>Same                                                                    |                                       |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.              |              | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Arteriosclerotic cerebro-vascular disease<br>(B) Encephalopathy - chronic due to 1 DUE TO, OR AS A CONSEQUENCE OF: above<br>(C) Encephalopathy - acute with para-<br>tonia and cerebral deterioration<br>Arteriosclerotic cardiovascular disease |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 mo.<br>2 mo.<br>2 mo.<br>10 yrs. |                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                           |              |                                                                                                                                                                                                                                                                                                                           |  |                                                                                    |                                       |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                      |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                          |  | 20A. AUTOPSY? (Yes or No)<br>No                                                    |                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                            |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)           |                                       |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                     |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                 |  | 21F. HOW DID INJURY OCCUR?                                                         |                                       |
| 22. I certify that (I) (this hospital) attended the deceased from February 19 64 to September 10, 1972, that (I) (we) last saw the deceased alive on September 2, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |              |                                                                                                                                                                                                                                                                                                                           |  |                                                                                    |                                       |
| 23A. SIGNATURE<br>Lloyd E. Saylor, M.D.                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                                                                                                                                                                                           |  | 23B. DATE SIGNED<br>Sept. 11, 1972                                                 |                                       |
| 23C. PHYSICIAN'S NAME (Type)<br>Lloyd E. Saylor M. D.                                                                                                                                                                                                                                                                            |              | 23D. ADDRESS<br>3902 Greenmount Avenue 21218                                                                                                                                                                                                                                                                              |  |                                                                                    |                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                               |              | 24B. DATE<br>9-13-72                                                                                                                                                                                                                                                                                                      |  | 24C. NAME OF CEMETERY or CREMATORY<br>Moreland Memorial Park                       |                                       |
|                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                           |  | 24D. LOCATION (City, town, or county) (State)<br>Balto. Co., Md.                   |                                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 11 1972                                                                                                                                                                                                                                                                                   |              | 25B. NAME OF REGISTRAR<br>Sidney Thornton                                                                                                                                                                                                                                                                                 |  | 25C. FUNERAL DIRECTOR<br>H. W. Jenkins & Sons Co.                                  |                                       |
|                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br>4905 York Road Balto., Md. 21212                                        |                                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                             |                                                                                                               |                                                                                                                                                             |                                                                                                                                                |                                                                                      |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 72 08705                                                                                                                                                                                                                                                                                                                    |                                                                                                               | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                                                                                                                                | 72 08705                                                                             |                                                           |
| BIRTH NO. <b>H-453</b>                                                                                                                                                                                                                                                                                                      |                                                                                                               | CERTIFICATE OF DEATH                                                                                                                                        |                                                                                                                                                | REG. NO. <b>72 08705</b>                                                             |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                      |                                                                                                               | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                                                                                                                                                | STATE OF MARYLAND - DEWITT                                                           |                                                           |
| HOLLAND, ADDIE VIRGINIA                                                                                                                                                                                                                                                                                                     |                                                                                                               | SEPT 7 1972                                                                                                                                                 |                                                                                                                                                | 6:20 P M.                                                                            |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                      |                                                                                                               | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                                                                       |                                                                                                                                                | 6300                                                                                 |                                                           |
| FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST AGNES HOSPITAL<br/>BALTO., MARYLAND</b>                                                                                                                                                                                          |                                                                                                               | A. STATE<br><b>MARYLAND</b>                                                                                                                                 |                                                                                                                                                | B. COUNTY<br><b>HOWARD CO</b>                                                        |                                                           |
| C. CITY OR TOWN<br><b>SIMPSONVILLE</b>                                                                                                                                                                                                                                                                                      |                                                                                                               | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                               |                                                                                                                                                |                                                                                      |                                                           |
| E. STREET AND NUMBER<br><b>RT 32 -</b>                                                                                                                                                                                                                                                                                      |                                                                                                               |                                                                                                                                                             |                                                                                                                                                |                                                                                      |                                                           |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>NEGRO</b>                                                                                       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9 15 01</b>                                                                                                             | 9. AGE (In years last birthday)<br><b>70</b>                                         | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HSWF.</b>                                                                                                                                                                                                                 |                                                                                                               | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                         |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                                                                                                                                                                                                                                                |                                                                                                               | 13. FATHER'S NAME<br><b>THOMAS BOARDLEY</b>                                                                                                                 |                                                                                                                                                | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE (BARNES)</b>                                    |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                       |                                                                                                               | 16. SOCIAL SECURITY NO.<br><b>216 14 3876</b>                                                                                                               |                                                                                                                                                | 17. INFORMANT ADDRESS<br><b>ST AGNES HOSPITAL-BALTO., MD.</b>                        |                                                           |
| 18. <b>199.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Metastatic Adenocarcinoma.</b>                                                                   |                                                                                                               | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                         |                                                                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                         |                                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                              |                                                                                                               | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                                                                                                                                                |                                                                                      |                                                           |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                         |                                                                                                               |                                                                                                                                                             |                                                                                                                                                |                                                                                      |                                                           |
| II                                                                                                                                                                                                                                                                                                                          |                                                                                                               |                                                                                                                                                             |                                                                                                                                                |                                                                                      |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                            |                                                                                                               |                                                                                                                                                             |                                                                                                                                                |                                                                                      |                                                           |
| 19A. DATE OF OPERATION<br><b>9-11-72</b>                                                                                                                                                                                                                                                                                    |                                                                                                               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                | 20A. AUTOPSY? (Yes or No)                                                            |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                              |                                                                                                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                   |                                                                                                               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                | 21F. HOW DID INJURY OCCUR?                                                           |                                                           |
| 22. I certify that (X) (this hospital) attended the deceased from <b>8 7 1972</b> to <b>9 7 19 72</b> , that (X) (we) last saw the deceased alive on <b>9 7 19 72</b> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. |                                                                                                               |                                                                                                                                                             |                                                                                                                                                |                                                                                      |                                                           |
| 23A. SIGNATURE<br> M.D. DEGREE                                                                                                                                                                                                           |                                                                                                               |                                                                                                                                                             |                                                                                                                                                | 23B. DATE SIGNED                                                                     |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>THIEN THITIVARANA</b>                                                                                                                                                                                                                                                                    |                                                                                                               |                                                                                                                                                             |                                                                                                                                                | 23D. ADDRESS<br><b>ST AGNES HOSPITAL-BALTO., MD.</b>                                 |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                    | 24B. DATE<br><b>9-11-72</b>                                                                                   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Locust Cem.</b>                                                                                                    |                                                                                                                                                | 24D. LOCATION (City, town, or county) (State)<br><b>Simpsonville, Howard Co, Md.</b> |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                       | 25B. NAME OF REGISTRAR<br> |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br> ADDRESS<br><b>Rockville, Md.</b> |                                                                                      |                                                           |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |           |                                                                                                                                                             |                         |                                                                                                                                                                                                                                                                                  |                                          |                                   |  |
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| H-423                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |           | 72 08706                                                                                                                                                    |                         | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                 |                                          | REQ. NO. 72 08706                 |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |           |                                                                                                                                                             |                         | STATE OF MARYLAND - DIME                                                                                                                                                                                                                                                         |                                          |                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print) Mrs. Mary Holste                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |           |                                                                                                                                                             |                         | 2. DATE AND HOUR OF DEATH<br>9-2-72 7:45 P.M.                                                                                                                                                                                                                                    |                                          |                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>90 Edgewood Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |           |                                                                                                                                                             |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 6000 Bellona Ave. |                                          |                                   |  |
| 5. SEX F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/5/84 | 9. AGE (in years last birthday) 88                                                                                                                                                                                                                                               | If Under 1 Yr. Months: Days: Hours: Min. |                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>self-employed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Dry Goods Store                                                                                                        |                         | 11. BIRTHPLACE (State or foreign country)<br>Md.                                                                                                                                                                                                                                 |                                          | 12. CITIZEN OF WHAT COUNTRY?<br>- |  |
| 13. FATHER'S NAME<br>Ludwig Schroeder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |           |                                                                                                                                                             |                         | 14. MOTHER'S MAIDEN NAME<br>Catherine Traeger                                                                                                                                                                                                                                    |                                          |                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |           | 16. SOCIAL SECURITY NO.<br>213-28-0256A                                                                                                                     |                         | 17. INFORMANT<br>Catherine Barrett (dghtr)                                                                                                                                                                                                                                       |                                          | ADDRESS<br>5915 Alameda           |  |
| 18. 412.2 + 250.9<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION 0<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No)<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)<br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>22. I certify that (I) (this hospital) attended the deceased from 9/2/71 to 9/2/71 that (I) (we) last saw the deceased alive on 9/2/71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE Anthony F. Carozza<br>23B. DATE SIGNED 9/4/72<br>23C. PHYSICIAN'S NAME (Type)<br>Anthony F. Carozza<br>23D. ADDRESS 5217 York Rd Balto Md.<br>24A. BURIAL CREMATION, REMOVAL (Specify) Burial<br>24B. DATE 9/6/72<br>24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk. Cemetery Balto. Md.<br>24D. LOCATION (City, town, or county) (State)<br>25A. DATE REC'D BY HEALTH DEPT. SEP 11 1972<br>25B. NAME OF REGISTRAR Anthony F. Carozza<br>25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213 |           |                                                                                                                                                             |                         |                                                                                                                                                                                                                                                                                  |                                          |                                   |  |

5915 The Alameda.

16/14/91

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-650 72 08707 BALTIMORE CITY HEALTH DEPARTMENT                                                                                              |  |                                                                                          |  | 72 08707                                                                                                 |  | REG. NO.                                                                                                                                                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                    |  |                                                                                          |  | STATE OF MARYLAND - DEPT. OF HEALTH                                                                      |  |                                                                                                                                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                       |  |                                                                                          |  | 2. DATE AND HOUR OF DEATH                                                                                |  |                                                                                                                                                                                                    |  |
| Byrne, WILLIAM EDWARD                                                                                                                        |  |                                                                                          |  | 9 - 4 - 72 5:45 A.M.                                                                                     |  |                                                                                                                                                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                       |  |                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                    |  |                                                                                                                                                                                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                    |  |                                                                                          |  | A. STATE                                                                                                 |  | B. COUNTY                                                                                                                                                                                          |  |
| 37 Mercy HOSPITAL                                                                                                                            |  |                                                                                          |  | Md.                                                                                                      |  | 1101                                                                                                                                                                                               |  |
| 5. SEX                                                                                                                                       |  |                                                                                          |  | 6. RACE                                                                                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>                                                                                                              |  |
| m                                                                                                                                            |  | w                                                                                        |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                       |  | 8. DATE OF BIRTH                                                                                                                                                                                   |  |
| 9. AGE (in years last birthday)                                                                                                              |  | 49                                                                                       |  | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)            |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                  |  |
| Clerk                                                                                                                                        |  | Western Md. R.R.                                                                         |  | 11. BIRTHPLACE (State or foreign country)                                                                |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                       |  |
| Md.                                                                                                                                          |  | yes USA                                                                                  |  | 13. FATHER'S NAME                                                                                        |  |                                                                                                                                                                                                    |  |
| William Edward                                                                                                                               |  |                                                                                          |  | 14. MOTHER'S MAIDEN NAME                                                                                 |  |                                                                                                                                                                                                    |  |
| Anna Marie Garrett                                                                                                                           |  |                                                                                          |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |                                                                                                                                                                                                    |  |
| yes WW II                                                                                                                                    |  |                                                                                          |  | 16. SOCIAL SECURITY NO.                                                                                  |  | 17. INFORMANT                                                                                                                                                                                      |  |
| 275-12-3938                                                                                                                                  |  | James Casey (friend)                                                                     |  | 1101 St. Paul St.                                                                                        |  |                                                                                                                                                                                                    |  |
| 18. CAUSE OF DEATH                                                                                                                           |  |                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |  |                                                                                                                                                                                                    |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                               |  |                                                                                          |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF                                                       |  |                                                                                                                                                                                                    |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  |                                                                                          |  | Cardiopulmonary Arrest                                                                                   |  |                                                                                                                                                                                                    |  |
| ANTECEDENT CAUSES                                                                                                                            |  |                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                      |  |                                                                                                                                                                                                    |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |  |                                                                                          |  | Pulmonary Edema                                                                                          |  |                                                                                                                                                                                                    |  |
| II                                                                                                                                           |  |                                                                                          |  | (C) Acute Myocardial Infarction                                                                          |  |                                                                                                                                                                                                    |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).             |  |                                                                                          |  | 20A. AUTOPSY? (Yes or No)                                                                                |  |                                                                                                                                                                                                    |  |
| 19A. DATE OF OPERATION                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | No                                                                                                       |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |  | 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                      |  |
| 21E. INJURY OCCURRED                                                                                                                         |  | 21F. HOW DID INJURY OCCUR?                                                               |  | 22. I certify that (1) (this hospital) attended the deceased from 8-24-72 to 9-4-72                      |  | that (1) (we) last saw the deceased alive on 9-4-72 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (not) view the body after death. |  |
| 23A. SIGNATURE                                                                                                                               |  |                                                                                          |  | 23B. DATE SIGNED                                                                                         |  | 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                       |  |
| Benedict A. Termini MD                                                                                                                       |  |                                                                                          |  | 9/4/72                                                                                                   |  | Benedict A. Termini MD                                                                                                                                                                             |  |
| 23D. ADDRESS                                                                                                                                 |  |                                                                                          |  | 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                 |  |                                                                                                                                                                                                    |  |
| Mercy Hosp                                                                                                                                   |  |                                                                                          |  | 24B. DATE 9/7/72                                                                                         |  |                                                                                                                                                                                                    |  |
| 24C. NAME OF CEMETERY or CREMATORY                                                                                                           |  |                                                                                          |  | 24D. LOCATION (City, town, or county) (State)                                                            |  |                                                                                                                                                                                                    |  |
| London Park Mausoleum                                                                                                                        |  |                                                                                          |  | Balto. Md.                                                                                               |  |                                                                                                                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                              |  |                                                                                          |  | 25B. NAME OF REGISTRAR                                                                                   |  |                                                                                                                                                                                                    |  |
| SEP 11 1972                                                                                                                                  |  |                                                                                          |  | Schimunek Funeral Homes, Inc., 3331 Brehms Lane, Balto. Md. 21213                                        |  |                                                                                                                                                                                                    |  |

Mercy

W m

Chief

William Edward

4 1-24-32

Ad.

Anna Marie Goulet

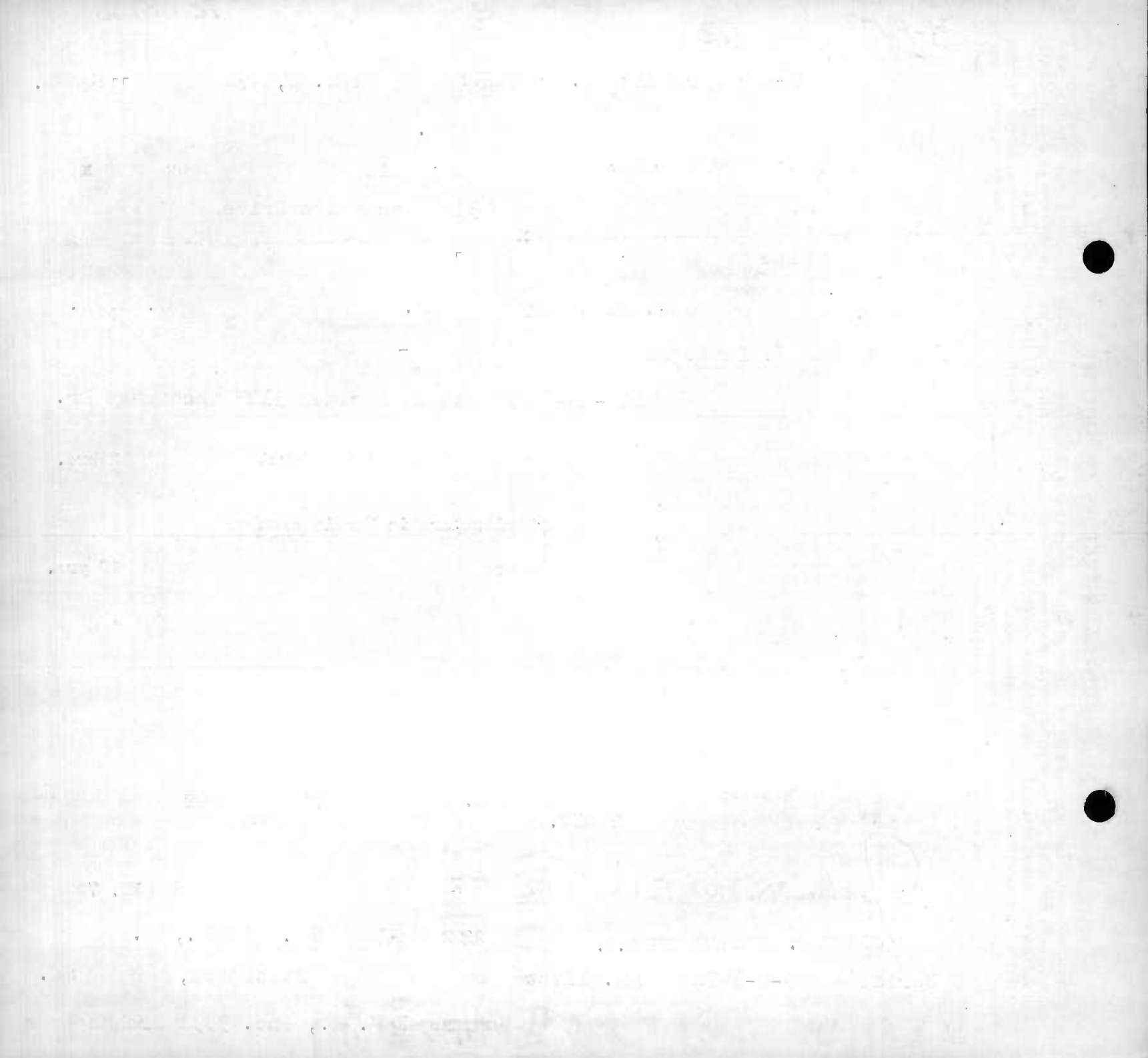
Cardiopharyngeal Aneurysm

Palmonary Embolism  
Acute Myocardial Infarction

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

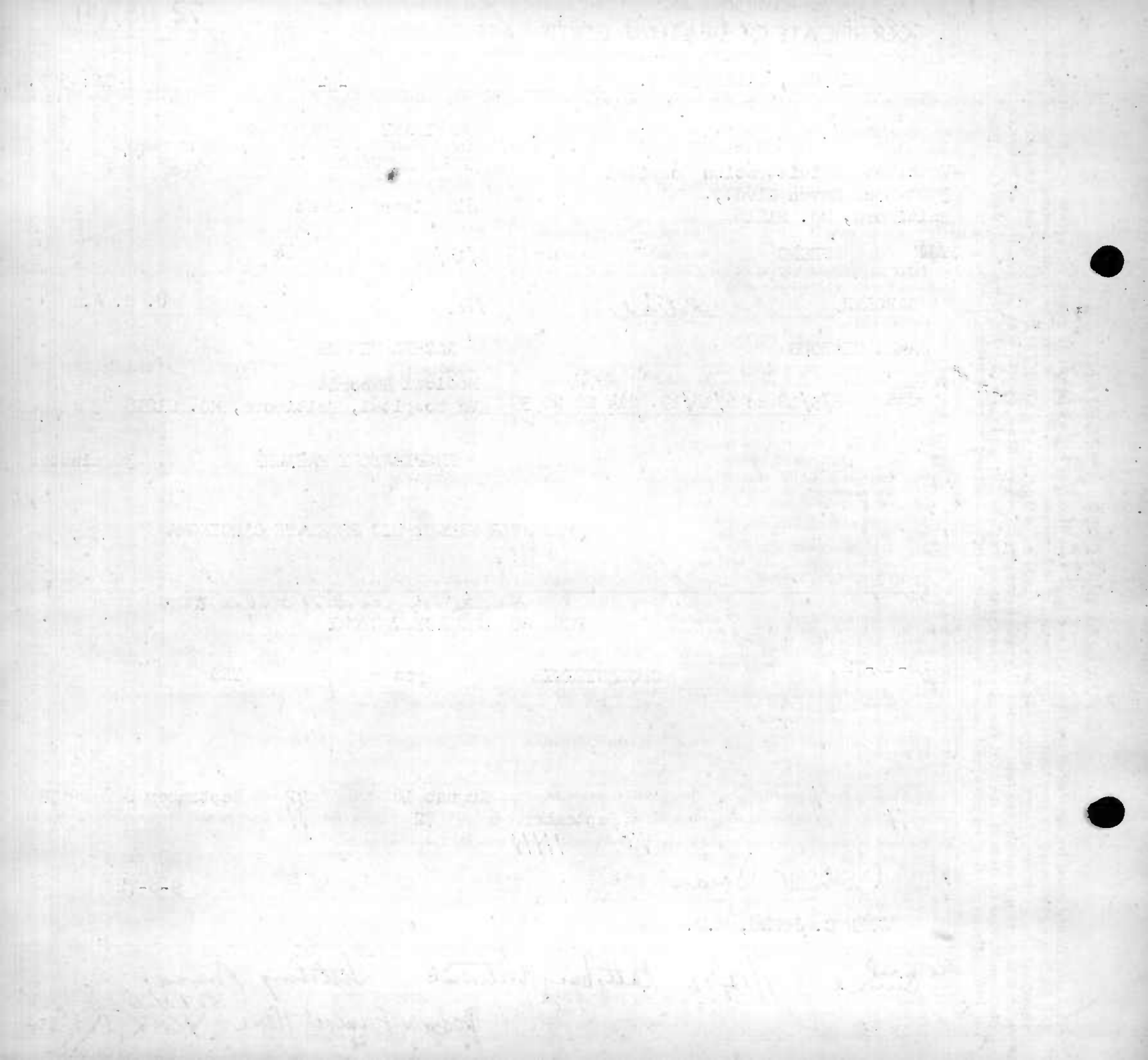
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 72 08708 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                           |  | REG. NO. 72 08708                                                                                                                                             |  |
| BIRTH NO. <b>1-125</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Frank (Francis) J. DeVaughn</b>                                                                                                                                                                                                                                               |  | 2. DATE AND HOUR OF DEATH<br><b>Sept. 2, 1972</b> <b>11:45 P.M.</b>                                                                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 Embrose Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>5210</b>                                                                                                                                                                                      |  | C. CITY OR TOWN <b>Annapolis</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |  |
| 5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 8. DATE OF BIRTH <b>2/19/88</b> 9. AGE (In years last birthday) <b>84</b>                                                                                                                                                                                                                                               |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Koesters Bakery</b>                                                                                                                                                                                                                                                                |  | 11. BIRTHPLACE (State or foreign country) <b>Md.</b>                                                                                                          |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13. FATHER'S NAME <b>William T. DeVaughn</b>                                                                                                                                                                                                                                                                            |  | 14. MOTHER'S MAIDEN NAME <b>-</b>                                                                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO. <b>212-10-6733</b>                                                                                                                                                                                                                                                                              |  | 17. INFORMANT ADDRESS <b>Stella Steiner 3127 Anchorage Dr.</b>                                                                                                |  |
| MEDICAL CERTIFICATION<br><br>18. <b>410.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><br>19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><br>20A. AUTOPSY? (Yes or No) <b>0</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><br>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br><br>21F. HOW DID INJURY OCCUR?<br><br>22. I certify that (I) (the deceased) attended the deceased from <b>JAN. 1971</b> to <b>SEPT. 1972</b> , that (I) last saw the deceased alive on <b>2 SEPT. 1972</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the deceased) (did not) view the body after death. |  | CAUSE OF DEATH<br><b>Myocardial Infarct</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><br><b>Arteriosclerotic Cardiovascular Disease</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br><b>Disease</b><br>(C)<br><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs.</b><br><br><b>10 yrs.</b> |  |                                                                                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23A. SIGNATURE <b>Joshua R. Mitchell III M.D.</b> 23B. DATE SIGNED <b>5 SEPT. 72</b>                                                                                                                                                                                                                                    |  | 23C. PHYSICIAN'S NAME (Type) <b>JOSHUA R. MITCHELL III M.D.</b> 23D. ADDRESS <b>2202 GARRISON BLVD. BALTO., MD.</b>                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>9-6-1972</b> 24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>                                                                                                               |  | 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 11 1972</b> 25B. NAME OF REGISTRAR <b>Schimunek, F. H., Inc.</b> 25C. FUNERAL DIRECTOR ADDRESS <b>3331 Brehms Lane</b> |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                             | 72 08709                                                                                                                                                                                                                                                                                                                         |                                              |
| 72 08709                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                             | 72 08709                                                                                                                                                                                                                                                                                                                         |                                              |
| BIRTH NO. <b>G-125</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                             | REG. NO. <b>STATE OF MARYLAND - DIME</b>                                                                                                                                                                                                                                                                                         |                                              |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GIBBONS, VALENTINE T.</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>9-6-72</b> <b>12:45 P.M.</b>                                                                                                                                                                                                                                                                     |                                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Veterans Administration Hospital<br/>3900 Loch Raven Blvd.,<br/>Baltimore, Md. 21218</b>                                                                               |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>HARTFORD</b><br>C. CITY OR TOWN <b>HAVRE DE GRACE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>616 Girard Street</b> |                                              |
| 5. SEX <b>MALE</b> 6. RACE <b>NEGRO</b>                                                                                                                                                                                                                                                                                                              | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6/14/88</b>                                                                                                                                                                                                                                                                                                  | 9. AGE (In years last birthday) <b>84</b>    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>                                                                                                                                                                                                                                           |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country) <b>Pan</b>                                                                                                                                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b> |
| 10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  |                                              |
| 13. FATHER'S NAME <b>JAMES GIBBONS</b>                                                                                                                                                                                                                                                                                                               |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME <b>RACHEL WILSON</b>                                                                                                                                                                                                                                                                                    |                                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 8/5/18 to 6/18/19</b>                                                                                                                                                                                                                |                                                                                                                                                             | 16. SOCIAL SECURITY NO. <b>214 20 20 39</b>                                                                                                                                                                                                                                                                                      |                                              |
|                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                             | 17. INFORMANT <b>Medical Records</b> ADDRESS <b>VA Hospital, Baltimore, Md. 21218</b>                                                                                                                                                                                                                                            |                                              |
| 18. <b>185 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>RESPIRATORY FAILURE</b>                                                                                                   |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>                                                                                                                                                                                                                                                                   |                                              |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.                                                                                                                                                                                                                       |                                                                                                                                                             | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>PROBABLE METASTATIC PROSTATE CARCINOMA</b><br>(B) PROBABLE METASTATIC PROSTATE CARCINOMA DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>? Acute myocardial infarction POST OP CHOLECYSTECTOMY</b>                                                                           |                                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  |                                              |
| 19A. DATE OF OPERATION <b>3-16-72</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CHOLECYSTITIS</b>                                                                                                                                                                                                                                                            |                                              |
| 20A. AUTOPSY? (Yes or No) <b>yes</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>                                                                                                                                                                                                                                                  |                                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                       |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                         |                                              |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                             |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  |                                              |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                            |                                                                                                                                                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                           |                                              |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  |                                              |
| 22. I certify that (1) (this hospital) attended the deceased from <b>August 16 19 72</b> to <b>September 6 19 72</b> , that (2) (we) last saw the deceased alive on <b>September 6 19 72</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  |                                              |
| 23A. SIGNATURE <b>John C. Jones</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                             | 23B. DATE SIGNED <b>9-8-72</b>                                                                                                                                                                                                                                                                                                   |                                              |
| 23C. PHYSICIAN'S NAME (Type) <b>JOHN C. JONES, M.D.</b>                                                                                                                                                                                                                                                                                              |                                                                                                                                                             | 23D. ADDRESS                                                                                                                                                                                                                                                                                                                     |                                              |
| 24A. BURIAL CREMATION, (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                                             | 24B. DATE <b>9/12/72</b>                                                                                                                                                                                                                                                                                                         |                                              |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Gettysburg National</b>                                                                                                                                                                                                                                                                                        |                                                                                                                                                             | 24D. LOCATION (City, town, or county) (State) <b>Gettysburg Penna.</b>                                                                                                                                                                                                                                                           |                                              |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 11 1972</b>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                             | 25B. NAME OF REGISTRAR <b>Sidney [illegible]</b>                                                                                                                                                                                                                                                                                 |                                              |
| 25C. FUNERAL DIRECTOR <b>Dodson Funeral Home</b>                                                                                                                                                                                                                                                                                                     |                                                                                                                                                             | 25D. ADDRESS <b>517 N. GEORGETOWN ST. YORK, PENNA.</b>                                                                                                                                                                                                                                                                           |                                              |







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                     | 72 08710                                                                                                                        |                                          | 72 08710                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| S-630                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                     | 72 08710                                                                                                                        |                                          | 72 08710                                                                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                     | 72 08710                                                                                                                        |                                          | 72 08710                                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lillie Mae Shird</b>                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                     | 2. DATE AND HOUR OF DEATH<br><b>9/7/72 12:22 pm</b>                                                                             |                                          |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                                           |                                          |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Bon Secours Hospital</b>                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                     | A. STATE<br><b>Md.</b>                                                                                                          |                                          | B. COUNTY<br><b>2002</b>                                                                      |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>2025 W. Fayette St.</b>                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                     | C. CITY OR TOWN<br><b>Balt</b>                                                                                                  |                                          | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>21223</b>                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                     | E. STREET AND NUMBER<br><b>2340 W. Fayette St.</b>                                                                              |                                          |                                                                                               |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>Black</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/3/-92</b> | 9. AGE (In years last birthday)<br><b>79</b>                                                                                    | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min.                                                                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                      |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>                                                                     |                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                 |  |
| 13. FATHER'S NAME<br><b>John McWhite</b>                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Maetha Bostick</b>                                                                               |                                          |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                |                         | 16. SOCIAL SECURITY NO.<br><b>250-64-8222</b>                                                                                                               |                                     | 17. INFORMANT ADDRESS<br><b>Mrs. Daisy Granges 2340 W. Fayette St. 21223</b>                                                    |                                          |                                                                                               |  |
| 18. <b>431.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Hemorrhage</b>                                                                    |                         |                                                                                                                                                             |                                     | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Hypertension</b>                                                      |                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>                                 |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>                                                                                                                                                                          |                         |                                                                                                                                                             |                                     | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                             |                                          | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                           |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                     |                         |                                                                                                                                                             |                                     |                                                                                                                                 |                                          |                                                                                               |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                     | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>                                                                   |                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                       |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                        |                                          |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                            |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                     | 21F. HOW DID INJURY OCCUR?                                                                                                      |                                          |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/2/72</b> to <b>9/7/72</b> that (I) (we) last saw the deceased alive on <b>9/7/72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                     |                                                                                                                                 |                                          |                                                                                               |  |
| 23A. SIGNATURE<br><b>Chauhan</b>                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                     | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                          | 23B. DATE SIGNED<br><b>9/7/72</b>                                                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CHAUHAN</b>                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                     | 23D. ADDRESS<br><b>Bon Secours 2025 W. Fayette St. 21223</b>                                                                    |                                          |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Transit-burial</b>                                                                                                                                                                                                                                                    |                         | 24B. DATE<br><b>9-10-72</b>                                                                                                                                 |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Aimwell Bapt. Church Cemetery</b>                                                      |                                          | 24D. LOCATION (City, town, or county) (State)<br><b>Pamplico, South Carolina</b>              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 11 1972</b>                                                                                                                                                                                                                                                                |                         | 25B. NAME OF REGISTRAR<br><b>Silvia...</b>                                                                                                                  |                                     | 25C. FUNERAL DIRECTOR 1735 Harford Ave. Address<br><b>Marshall W. Jones Jr. Balt. Md.</b>                                       |                                          |                                                                                               |  |



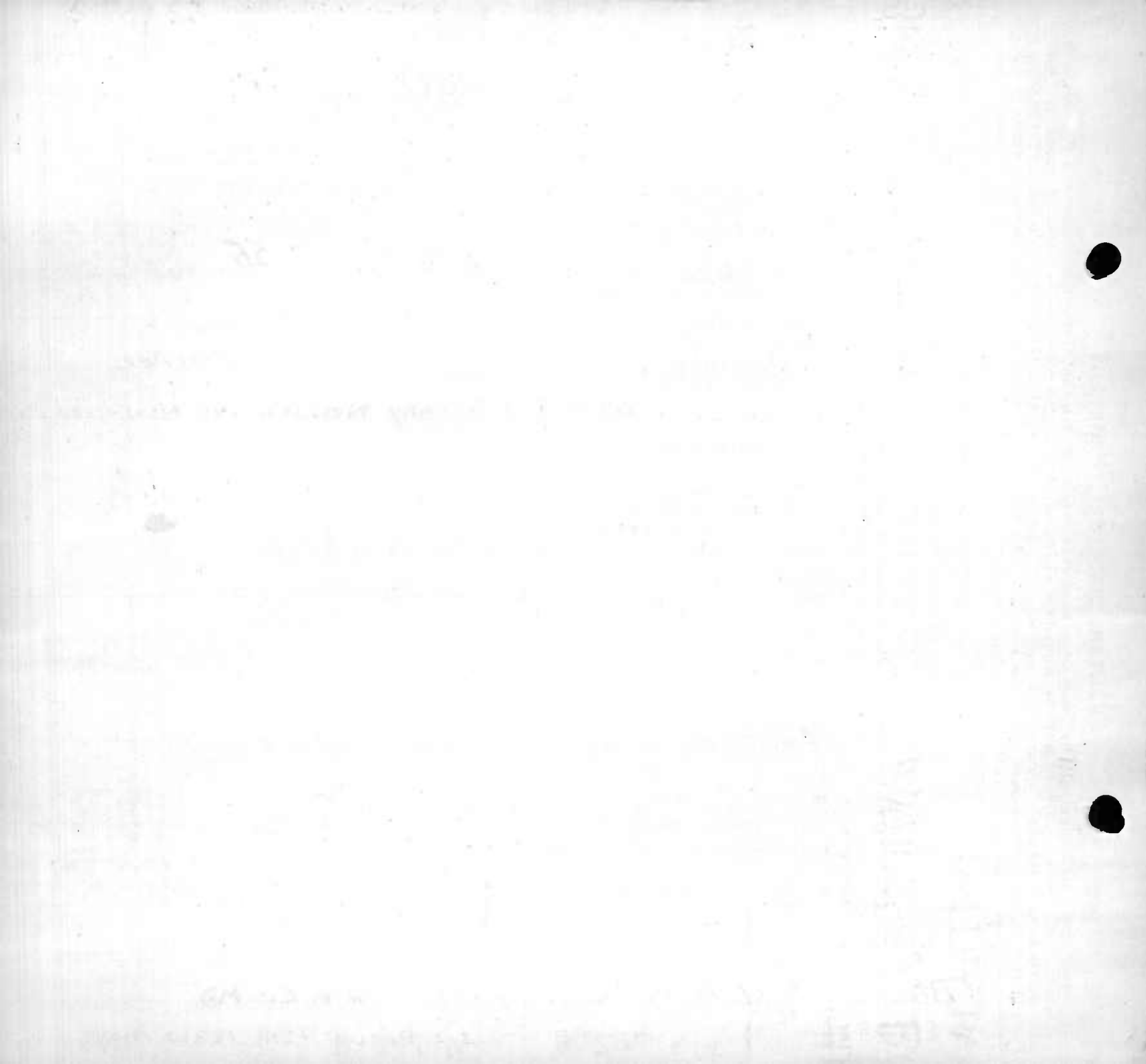
| STATE OF MARYLAND - DHMH<br>BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                               |  | 72 08711                                                                                                                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                               |  | REG. NO. _____                                                                                                                                                                                          |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ALEXANDER DEMBY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                               |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>September</b> Day <b>3</b> Year <b>1972</b> Hour <b>M.</b>                                    |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>University Hospital (DOA)</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                               |  | 3. DATE PRONOUNCED DEAD<br>Month <b>September</b> Day <b>3</b> Year <b>1972</b> Hour <b>2:20 A.M.</b>                                                                                                   |  |
| 6. SEX <b>Male</b> 7. RACE <b>Negro</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                               |  | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>HARFORD 6200</b>                                                         |  |
| 9. DATE OF BIRTH <b>NOV 28 1946</b> 10. AGE (In years lost birthday) <b>25</b> 11. BIRTHPLACE (State or foreign country) <b>HARFORD CO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                               |  | C. CITY OR TOWN <b>Churchill</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                        |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                               |  | E. STREET AND NUMBER <b>Box 568 Asbury Road</b>                                                                                                                                                         |  |
| 13. FATHER'S NAME <b>ALEXANDER DEMBY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                               |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>                                                                                               |  |
| 15. MOTHER'S MAIDEN NAME <b>EVELYN SMITH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                               |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>                                                                                       |  |
| 17. SOCIAL SECURITY NO. <b>218-46-0955</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                               |  | 18. INFORMANT <b>CAROLINE DEMBY</b> ADDRESS _____                                                                                                                                                       |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>II<br>20A. DATE OF OPERATION <b>9-7-72</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 21. AUTOPSY? (Yes or No) <b>Yes</b> |  |                                               |  | (A) IMMEDIATE CAUSE<br>Gunshot wound of abdomen<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>(C) _____                                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>                                                                                                  |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Asbury Road, Churchill, Md. 6200</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                               |  | 22D. TIME OF INJURY (APPROX.) <b>9-3-72 12:52 A.</b>                                                                                                                                                    |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                               |  | 22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>                                                                                                                                             |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                                                                                                                     |  |                                               |  |                                                                                                                                                                                                         |  |
| ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>September 3, 1972</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE <b>9-7-72</b>                       |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Asbury Ch Cem</b>                                                                                                                                                 |  |
| 24D. LOCATION (City, town, or county) <b>Churchville Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | (State) _____                                 |  |                                                                                                                                                                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR <b>George W Tittle</b> |  | 25C. FUNERAL DIRECTOR <b>BEAIR</b>                                                                                                                                                                      |  |
| ADDRESS _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | ADDRESS _____                                 |  |                                                                                                                                                                                                         |  |

CHURCHVILLE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                             |  |  |  | 72 08712                                                                                                                         |  | 72 08712                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| M-532                                                                                                                                        |  |  |  | 72 08712                                                                                                                         |  | 72 08712                                                                              |  |
| BIRTH NO.                                                                                                                                    |  |  |  | 72 08712                                                                                                                         |  | 72 08712                                                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                       |  |  |  | 2. DATE AND HOUR OF DEATH                                                                                                        |  | REG. NO.                                                                              |  |
| Montgomery, Pearl (GUMBY)                                                                                                                    |  |  |  | Sept 10 1972                                                                                                                     |  | 4 <sup>15</sup> A.M.                                                                  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                       |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                            |  | A. STATE                                                                              |  |
| University Hospital                                                                                                                          |  |  |  | Maryland                                                                                                                         |  | 1601                                                                                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                    |  |  |  | C. CITY OR TOWN                                                                                                                  |  | D. INSIDE CITY LIMITS?                                                                |  |
| University Hospital                                                                                                                          |  |  |  | Baltimore                                                                                                                        |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 5. SEX                                                                                                                                       |  |  |  | 6. RACE                                                                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| F                                                                                                                                            |  |  |  | N                                                                                                                                |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                |  | 8. DATE OF BIRTH                                                                      |  |
| Housewife                                                                                                                                    |  |  |  |                                                                                                                                  |  | 1-16-1917                                                                             |  |
| 13. FATHER'S NAME                                                                                                                            |  |  |  | 14. MOTHER'S MAIDEN NAME                                                                                                         |  | 9. AGE (In years last birthday)                                                       |  |
| JACK DOWNEY                                                                                                                                  |  |  |  | ELIZABETH HARPER                                                                                                                 |  | 55                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                     |  |  |  | 16. SOCIAL SECURITY-NO.                                                                                                          |  | 17. INFORMANT                                                                         |  |
|                                                                                                                                              |  |  |  | 212-16-8218                                                                                                                      |  | JOHNNY NEWTON                                                                         |  |
| 18. CAUSE OF DEATH                                                                                                                           |  |  |  | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |
| I                                                                                                                                            |  |  |  | Acute MI                                                                                                                         |  | 1 hr.                                                                                 |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                              |  |                                                                                       |  |
| ANTECEDENT CAUSES                                                                                                                            |  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |                                                                                       |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |  |  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |                                                                                       |  |
| II                                                                                                                                           |  |  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |                                                                                       |  |
| 19A. DATE OF OPERATION                                                                                                                       |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20A. AUTOPSY? (Yes or No)                                                             |  |
| 0                                                                                                                                            |  |  |  |                                                                                                                                  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                        |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                         |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                |  |  |  | 21E. INJURY OCCURRED                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                            |  |
| (Month) (Day) (Year) (Hour)                                                                                                                  |  |  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                |  |                                                                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from                                                                            |  |  |  | Sept 10 1972                                                                                                                     |  | to                                                                                    |  |
| that (I) (we) last saw the deceased alive on                                                                                                 |  |  |  | Sept 10 1972                                                                                                                     |  | and that in (my) (our) opinion death occurred on the date                             |  |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                               |  |  |  |                                                                                                                                  |  |                                                                                       |  |
| 23A. SIGNATURE                                                                                                                               |  |  |  | 23B. DATE SIGNED                                                                                                                 |  | 23C. PHYSICIAN'S NAME (Type)                                                          |  |
| Lawrence Mills J. MD                                                                                                                         |  |  |  | 9/10/72                                                                                                                          |  | LAWRENCE MILLS J. MD                                                                  |  |
| 23D. ADDRESS                                                                                                                                 |  |  |  | 23E. FUNERAL DIRECTOR                                                                                                            |  | 23F. ADDRESS                                                                          |  |
| Univ. Hosp.                                                                                                                                  |  |  |  | T.L. Baggett & Son                                                                                                               |  | 123 W. Montgomery St.                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                     |  |  |  | 24B. DATE                                                                                                                        |  | 24C. NAME OF CEMETERY or CREMATORY                                                    |  |
| Burial                                                                                                                                       |  |  |  | 9-14-72                                                                                                                          |  | MT. CALVARY CEM.                                                                      |  |
| 24D. LOCATION (City, town, or county) (State)                                                                                                |  |  |  | 24E. ADDRESS                                                                                                                     |  | 24F. ADDRESS                                                                          |  |
| A.A. Co. MD                                                                                                                                  |  |  |  |                                                                                                                                  |  |                                                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                              |  |  |  | 25B. NAME OF REGISTRAR                                                                                                           |  | 25C. FUNERAL DIRECTOR                                                                 |  |
| SEP 13 1972                                                                                                                                  |  |  |  | T.L. Baggett & Son                                                                                                               |  | 123 W. Montgomery St.                                                                 |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                            |  |                                                                                                                                                          |  | 72 08713                                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                        |  |                                                                                                                                                          |  | REG. NO. 72 08713                                                                                         |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                      |  | 2. DATE AND HOUR OF DEATH                                                                                                                                |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                    |  |
| Frances DeAngelis                                                                                                                                                                                                                                                                           |  | September 11, 1972 1:30 P.M.                                                                                                                             |  | FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |  |
| 3527 Claremont Avenue                                                                                                                                                                                                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                                                    |  | 5. SEX                                                                                                    |  |
| Maryland                                                                                                                                                                                                                                                                                    |  | A. STATE B. COUNTY                                                                                                                                       |  | Fem. Caucasian                                                                                            |  |
| C. CITY OR TOWN                                                                                                                                                                                                                                                                             |  | D. INSIDE CITY LIMITS?                                                                                                                                   |  | 6. RACE                                                                                                   |  |
| Baltimore                                                                                                                                                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | Caucasian                                                                                                 |  |
| E. STREET AND NUMBER                                                                                                                                                                                                                                                                        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH                                                                                          |  |
| 3527 Claremont Avenue                                                                                                                                                                                                                                                                       |  |                                                                                                                                                          |  | 9/18/96                                                                                                   |  |
| 9. AGE (In years last birthday)                                                                                                                                                                                                                                                             |  | 10. KIND OF BUSINESS OR INDUSTRY                                                                                                                         |  | 11. BIRTHPLACE (State or foreign country)                                                                 |  |
| 75 75                                                                                                                                                                                                                                                                                       |  | home                                                                                                                                                     |  | Baltimore Co., Maryland                                                                                   |  |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                |  | 13. FATHER'S NAME                                                                                                                                        |  | 14. MOTHER'S MAIDEN NAME                                                                                  |  |
| U.S.A.                                                                                                                                                                                                                                                                                      |  | unk                                                                                                                                                      |  | unk                                                                                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO.                                                                                                                                  |  | 17. INFORMANT ADDRESS                                                                                     |  |
| no                                                                                                                                                                                                                                                                                          |  | 212-22-0680                                                                                                                                              |  | Mrs. Rita Padgett, 815 S. Streeper St.                                                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                          |  | CAUSE OF DEATH                                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                              |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                |  | Hypertensive cardiac - Vascular                                                                                                                          |  |                                                                                                           |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                           |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |  |                                                                                                           |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                   |  | Chronic                                                                                                                                                  |  |                                                                                                           |  |
|                                                                                                                                                                                                                                                                                             |  | (B) Due to, or as a consequence of:                                                                                                                      |  |                                                                                                           |  |
|                                                                                                                                                                                                                                                                                             |  | (C) Due to, or as a consequence of:                                                                                                                      |  |                                                                                                           |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                            |  |                                                                                                                                                          |  |                                                                                                           |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                 |  |
|                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                          |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                  |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                               |  | 21E. INJURY OCCURRED                                                                                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                |  |
|                                                                                                                                                                                                                                                                                             |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                        |  |                                                                                                           |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8 to 9/11 1972 that (I) (we) last saw the deceased alive on 9/8 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |                                                                                                                                                          |  |                                                                                                           |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                              |  | 23B. DATE SIGNED                                                                                                                                         |  | 23C. PHYSICIAN'S NAME (Type)                                                                              |  |
| J.R. LIBERTO, MD                                                                                                                                                                                                                                                                            |  | 9/12/72                                                                                                                                                  |  | J.R. LIBERTO, MD                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                    |  | 24B. DATE                                                                                                                                                |  | 24C. NAME of CEMETERY or CREMATORY                                                                        |  |
| Burial                                                                                                                                                                                                                                                                                      |  | 9/14/72                                                                                                                                                  |  | Holy Redeemer Cemetery                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                             |  | 25B. NAME OF REGISTRAR                                                                                                                                   |  | 25C. FUNERAL DIRECTOR ADDRESS                                                                             |  |
| SEP 13 1972                                                                                                                                                                                                                                                                                 |  | Joseph N. Zannino                                                                                                                                        |  | Joseph N. Zannino, 263 S. Conkling Street                                                                 |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

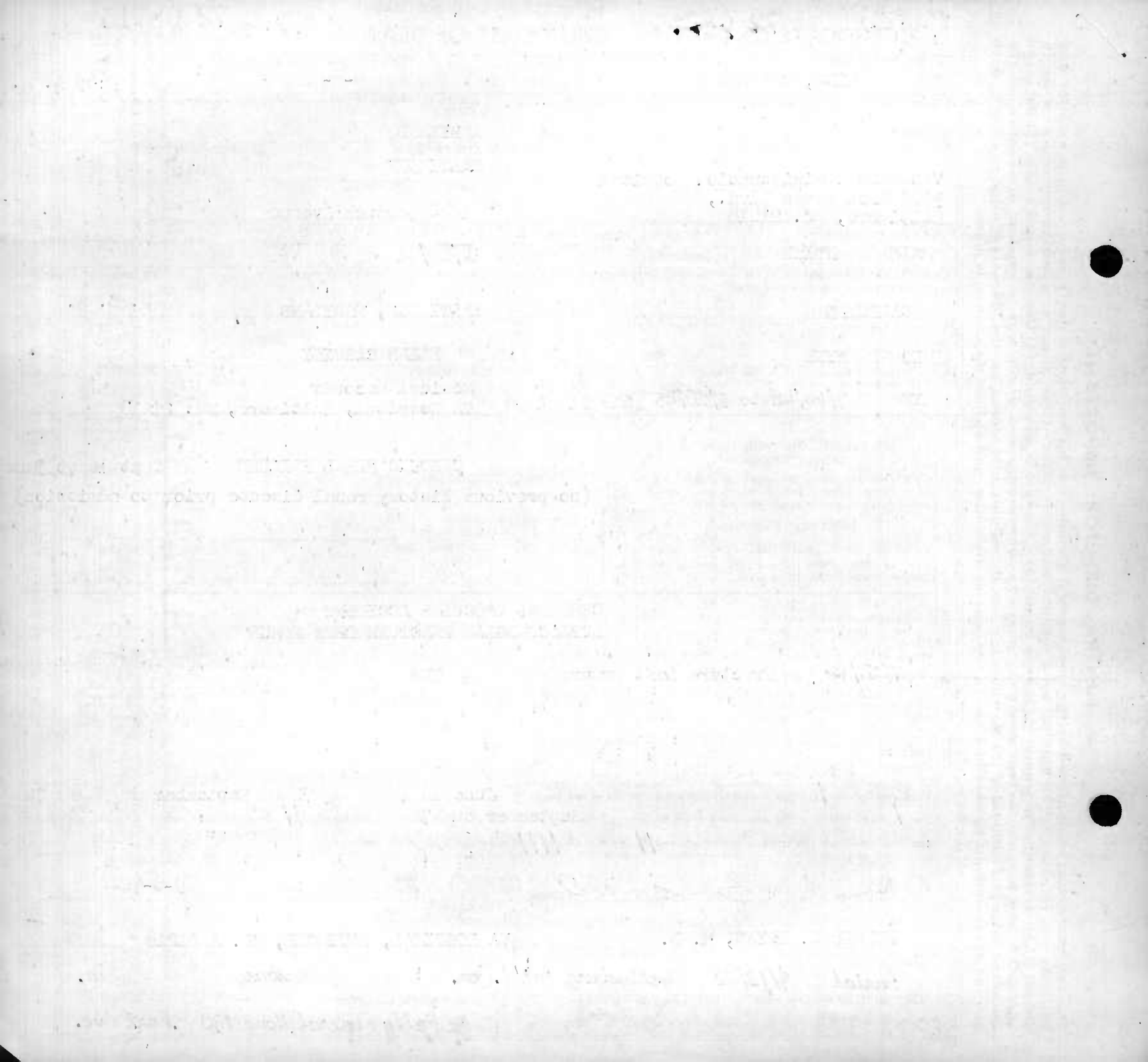
|                                                                                                           |              |                                                                                                                                                             |                             |                                                                                                                                                          |                                                        |
|-----------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                          |              | 72 08714                                                                                                                                                    |                             | 72 08714                                                                                                                                                 |                                                        |
| N-000                                                                                                     |              | 71-10067                                                                                                                                                    |                             | 72 08714                                                                                                                                                 |                                                        |
| BIRTH NO.                                                                                                 |              | 71-10067                                                                                                                                                    |                             | 72 08714                                                                                                                                                 |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                    |              | Sean Nye                                                                                                                                                    |                             | 2. DATE AND HOUR OF DEATH<br>9/9/72 8:25AM                                                                                                               |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                    |              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY                                                 |                             | 5. CITY OR TOWN                                                                                                                                          |                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |              | Md. Baltimore City 2533                                                                                                                                     |                             | Baltimore                                                                                                                                                |                                                        |
| University of Maryland Hospital                                                                           |              | E. STREET AND NUMBER                                                                                                                                        |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                            |                                                        |
| 38                                                                                                        |              | 2805 Indiana St.                                                                                                                                            |                             |                                                                                                                                                          |                                                        |
| 6. SEX<br>M                                                                                               | 7. RACE<br>W | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. DATE OF BIRTH<br>6/16/71 | 10. AGE (in years last birthday)<br>1                                                                                                                    | 11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)               |              | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                             | 11. BIRTHPLACE (State or foreign country)                                                                                                                |                                                        |
| Child                                                                                                     |              | —                                                                                                                                                           |                             | Maryland                                                                                                                                                 |                                                        |
| 12. FATHER'S NAME                                                                                         |              | 13. MOTHER'S MAIDEN NAME                                                                                                                                    |                             | 14. CITIZEN OF WHAT COUNTRY?                                                                                                                             |                                                        |
| Roger Nye                                                                                                 |              | Ella Himes                                                                                                                                                  |                             | USA                                                                                                                                                      |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |              | 16. SOCIAL SECURITY NO.                                                                                                                                     |                             | 17. INFORMANT                                                                                                                                            |                                                        |
| no                                                                                                        |              | none                                                                                                                                                        |                             | medical record                                                                                                                                           |                                                        |
| 18. CAUSE OF DEATH                                                                                        |              | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                              |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |                                                        |
| 2050 I                                                                                                    |              | (A) IMMEDIATE CAUSE PROBABLE SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                      |                             | 1 yr.                                                                                                                                                    |                                                        |
| ANTECEDENT CAUSES                                                                                         |              | (B) Acute myelogenous leukemia<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                           |                             |                                                                                                                                                          |                                                        |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |              | (C) _____                                                                                                                                                   |                             |                                                                                                                                                          |                                                        |
| II                                                                                                        |              | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                            |                             | None                                                                                                                                                     |                                                        |
| 19A. DATE OF OPERATION                                                                                    |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                             | 20A. AUTOPSY? (Yes or No)                                                                                                                                |                                                        |
| None                                                                                                      |              | —                                                                                                                                                           |                             | YES                                                                                                                                                      |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                     |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |                                                        |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                 |              | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>                                                   |                             | 21F. HOW DID INJURY OCCUR?                                                                                                                               |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from 8/25 19 72 to 9/9 19 72                 |              | that (I) (we) last saw the deceased alive on 9/9 19 72                                                                                                      |                             | and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                        |
| 23A. SIGNATURE                                                                                            |              | 23B. DATE SIGNED                                                                                                                                            |                             | 23C. PHYSICIAN'S NAME (Type)                                                                                                                             |                                                        |
| Harold Magalnick MD                                                                                       |              | 9-9-72                                                                                                                                                      |                             | HAROLD MAGALNICK MD                                                                                                                                      |                                                        |
| 23D. ADDRESS                                                                                              |              | 23E. DATE                                                                                                                                                   |                             | 23F. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                        |
| University of Maryland Hosp Md.                                                                           |              | 9-13-72                                                                                                                                                     |                             | Cedar Hill Cemetery                                                                                                                                      |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                  |              | 24B. LOCATION (City, town, or county) (State)                                                                                                               |                             | 24C. DATE REC'D BY HEALTH DEPT.                                                                                                                          |                                                        |
| Burial                                                                                                    |              | Balto. Md.                                                                                                                                                  |                             | 25A. NAME OF REGISTRAR                                                                                                                                   |                                                        |
| 25B. DATE REC'D BY HEALTH DEPT.                                                                           |              | 25C. FUNERAL DIRECTOR                                                                                                                                       |                             | 25D. ADDRESS                                                                                                                                             |                                                        |
| SEP 13 1972                                                                                               |              | McCutty Funeral Home 130 E. Font Ave. 21230                                                                                                                 |                             | 25E. NAME OF REGISTRAR                                                                                                                                   |                                                        |
| VS 150-REV. 1/1/68                                                                                        |              |                                                                                                                                                             |                             |                                                                                                                                                          |                                                        |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

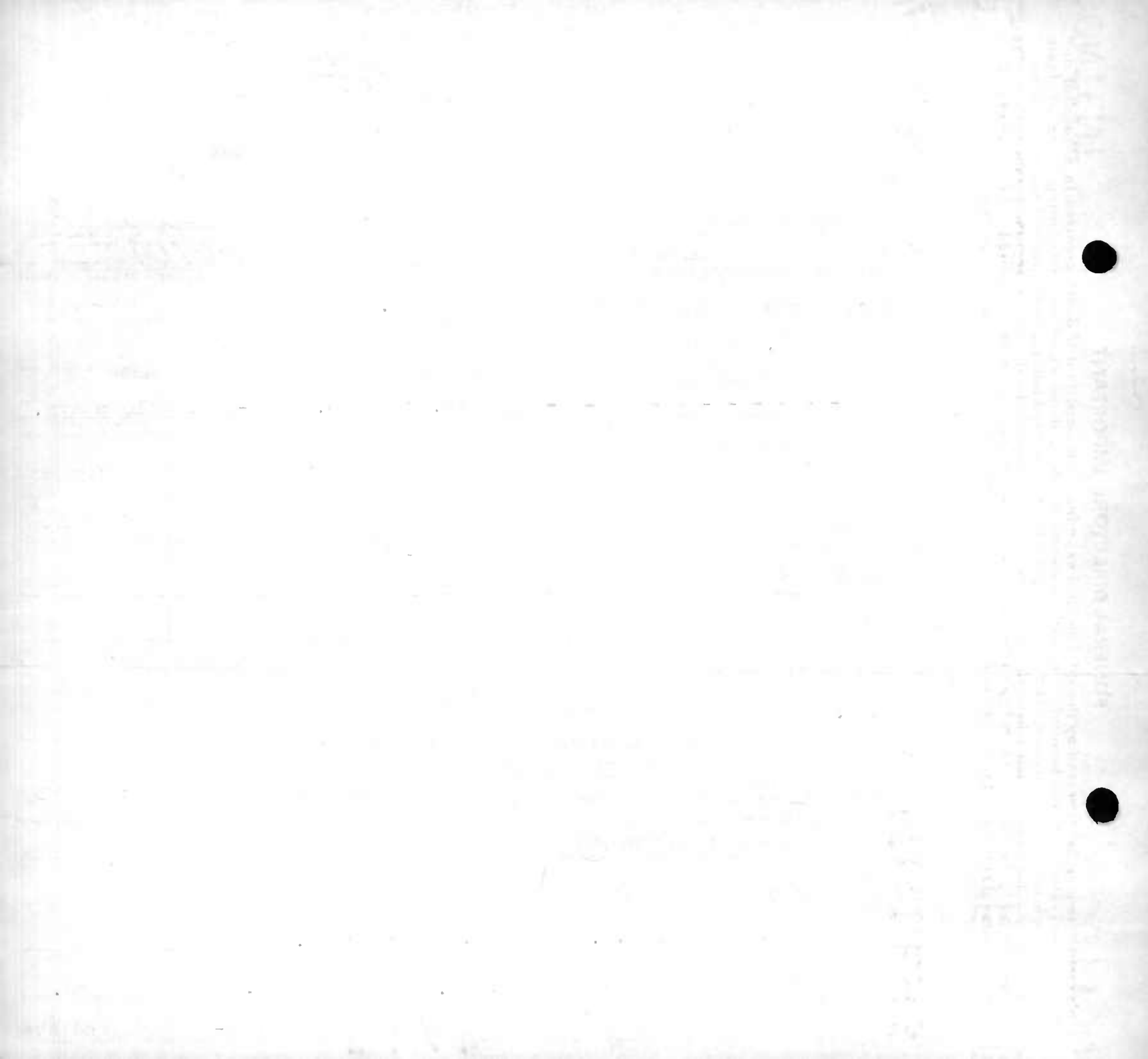
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                        |  |                                                   |                                                                                                                                           | REG. NO. <b>72 08715</b>                                               |                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| K-500 72 08715                                                                                                                                                                                                                                                                                                                                                          |  |                                                   |                                                                                                                                           |                                                                        |                                                                                                                                                             |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |                                                                                                                                           |                                                                        |                                                                                                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>KYNE, CHARLES A</b>                                                                                                                                                                                                                                                                                                           |  |                                                   | 2. DATE AND HOUR OF DEATH<br><b>9-8-72</b> <b>9:45 A. M.</b>                                                                              |                                                                        |                                                                                                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Veterans Administration Hospital<br/>3900 Loch Raven Blvd.,<br/>Baltimore, Md. 21218</b>                                                                                                  |  |                                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>907</b> |                                                                        |                                                                                                                                                             |
| 5. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                   | 6. RACE <b>WHITE</b>                                                                                                                      |                                                                        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>                                                                                                                                                                                                                                                          |  |                                                   | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                         |                                                                        | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>                                                                                     |
| 13. FATHER'S NAME<br><b>MICHAEL KYNE</b>                                                                                                                                                                                                                                                                                                                                |  |                                                   | 14. MOTHER'S MAIDEN NAME<br><b>ELLEN CASSIDY</b>                                                                                          |                                                                        |                                                                                                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)<br><b>YES</b>                                                                                                                                                                                                                                                                                         |  |                                                   | 16. SOCIAL SECURITY NO.<br><b>216 01 81 98</b>                                                                                            |                                                                        | 17. INFORMANT<br><b>Medical Records<br/>VA Hospital, Baltimore, Md. 21218</b>                                                                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means injury or complication which caused death.)<br><b>CHRONIC RENAL FAILURE</b><br><b>? at least 3mos</b>                                                                                                                         |  |                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                              |                                                                        |                                                                                                                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                          |  |                                                   | (A) IMMEDIATE CAUSE<br><b>CHRONIC RENAL FAILURE</b><br><b>(no previous history renal disease prior to admission)</b>                      |                                                                        |                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                         |  |                                                   | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cerebral Infarction</b>                                                                         |                                                                        |                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                         |  |                                                   | (C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>ASCVD</b>                                                                                       |                                                                        |                                                                                                                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                  |  |                                                   | <b>CEREBRAL VASCULAR ACCIDENT</b><br><b>SUPRACONDYLAR FRACTURE LEFT FEMUR</b>                                                             |                                                                        |                                                                                                                                                             |
| 19A. DATE OF OPERATION<br><b>7/18/72</b>                                                                                                                                                                                                                                                                                                                                |  |                                                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fracture Left Femur</b>                                                            |                                                                        | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                       |  |                                                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                                   |                                                                        | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><b>1544 Gorsuch Ave</b>                                                      |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>6 - 16-72 PM</b>                                                                                                                                                                                                                                                                                     |  |                                                   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                      |                                                                        | 21F. HOW DID INJURY OCCUR?<br><b>Fell in his Room</b>                                                                                                       |
| 22. I certify that (1) (this hospital) attended the deceased from <b>June 16</b> 19 <b>72</b> to <b>September 8</b> 19 <b>72</b> , that (1) (we) last saw the deceased alive on <b>September 8</b> 19 <b>72</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death. |  |                                                   |                                                                                                                                           |                                                                        |                                                                                                                                                             |
| 23A. SIGNATURE<br><b>X Donald W. Bryan, M.D.</b>                                                                                                                                                                                                                                                                                                                        |  |                                                   |                                                                                                                                           |                                                                        | 23B. DATE SIGNED<br><b>9-8-72</b>                                                                                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DONALD W. BRYAN, M. D.</b>                                                                                                                                                                                                                                                                                                           |  |                                                   |                                                                                                                                           |                                                                        | 23D. ADDRESS<br><b>VA HOSPITAL, BALTIMORE, MD. A 21218</b>                                                                                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                               |  | 24B. DATE<br><b>9/12/72</b>                       |                                                                                                                                           | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Gettysburg Nat'l. Cem.</b>    |                                                                                                                                                             |
| 24D. LOCATION (City, town, or county)<br><b>Gettysburg</b>                                                                                                                                                                                                                                                                                                              |  | 24E. LOCATION (State)<br><b>Pa.</b>               |                                                                                                                                           |                                                                        |                                                                                                                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR<br><b>Andrew H. Hinton</b> |                                                                                                                                           | 25C. FUNERAL DIRECTOR<br><b>Mc Gally Funeral Home 130 E. Font Ave.</b> |                                                                                                                                                             |
| 25D. ADDRESS<br><b>VS 150-REV. 1/1/68</b>                                                                                                                                                                                                                                                                                                                               |  |                                                   |                                                                                                                                           |                                                                        |                                                                                                                                                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                                             |                            | REG. NO. 72 08716                                                                                                    |                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| S-530 72 08716                                                                                                                                                                                                                                                                                                                                                                                  |                  | 72 08716                                                                                                                                                                    |                            | STATE OF MARYLAND-DEM                                                                                                |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                       |                  | 1. NAME OF DECEASED<br>(Type or Print) John Smith                                                                                                                           |                            | 2. DATE AND HOUR OF DEATH<br>Sept 9 1972 11:01 P.M.                                                                  |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                          |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY BALTIMORE                                              |                            | C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>MARYLAND GENERAL HOSPITAL 48                                                                                                                                                                                                                                                                                                                            |                  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                        |                            | E. STREET AND NUMBER<br>1201 WELDON AVE                                                                              |                                                           |
| 5. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                  | 6. RACE<br>WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 | 8. DATE OF BIRTH<br>5-3-01 | 9. AGE in years (last birthday)<br>71                                                                                | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Clerk                                                                                                                                                                                                                                                                                            |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Commercial Credit                                                                                                                      |                            | 11. BIRTHPLACE (State or foreign country)<br>Md.                                                                     |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                             |                  | 13. FATHER'S NAME<br>Thomas L. Smith                                                                                                                                        |                            | 14. MOTHER'S MAIDEN NAME<br>Chilcote                                                                                 |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                  |                  | 16. SOCIAL SECURITY NO.<br>212-10-7298                                                                                                                                      |                            | 17. INFORMANT<br>Mrs. Eursie W. Smith-1201 Weldon Ave.                                                               |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>41241<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>CARDIO VASCULAR Arrest minutes<br>(B) SEVERE Atherosclerotic CARDIOVASCULAR DISEASE ? YEARS<br>(C) |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                         |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                          |                  |                                                                                                                                                                             |                            |                                                                                                                      |                                                           |
| 19A. DATE OF OPERATION<br>Sept 1, 1972                                                                                                                                                                                                                                                                                                                                                          |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Aortic aneurysm resected                                                                                                |                            | 20A. AUTOPSY? (Yes or No)                                                                                            |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                           |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                    |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                             |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                                    |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                   |                            | 21F. HOW DID INJURY OCCUR?                                                                                           |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from 7/5 19 72 to 9/9 19 72 that (I) (we) last saw the deceased alive on 9/9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                        |                  |                                                                                                                                                                             |                            |                                                                                                                      |                                                           |
| 23A. SIGNATURE<br>Robert A. Cooper MD                                                                                                                                                                                                                                                                                                                                                           |                  | 23B. DATE SIGNED<br>9/9/72                                                                                                                                                  |                            | 23C. PHYSICIAN'S NAME (Type)<br>Robert A. Cooper, M.D.                                                               |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                              |                  | 24B. DATE<br>9/13/72                                                                                                                                                        |                            | 24C. NAME OF CEMETERY or CREMATORY<br>Meadowridge Mem. Pk.                                                           |                                                           |
| 24D. LOCATION<br>Howard Co.                                                                                                                                                                                                                                                                                                                                                                     |                  | 24E. STATE<br>Md.                                                                                                                                                           |                            | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                       |                                                           |
| 25B. NAME OF REGISTRAR<br>Lidney                                                                                                                                                                                                                                                                                                                                                                |                  | 25C. FUNERAL DIRECTOR<br>Donoyan Funeral Home-3818 Roland Ave                                                                                                               |                            | 25D. ADDRESS                                                                                                         |                                                           |

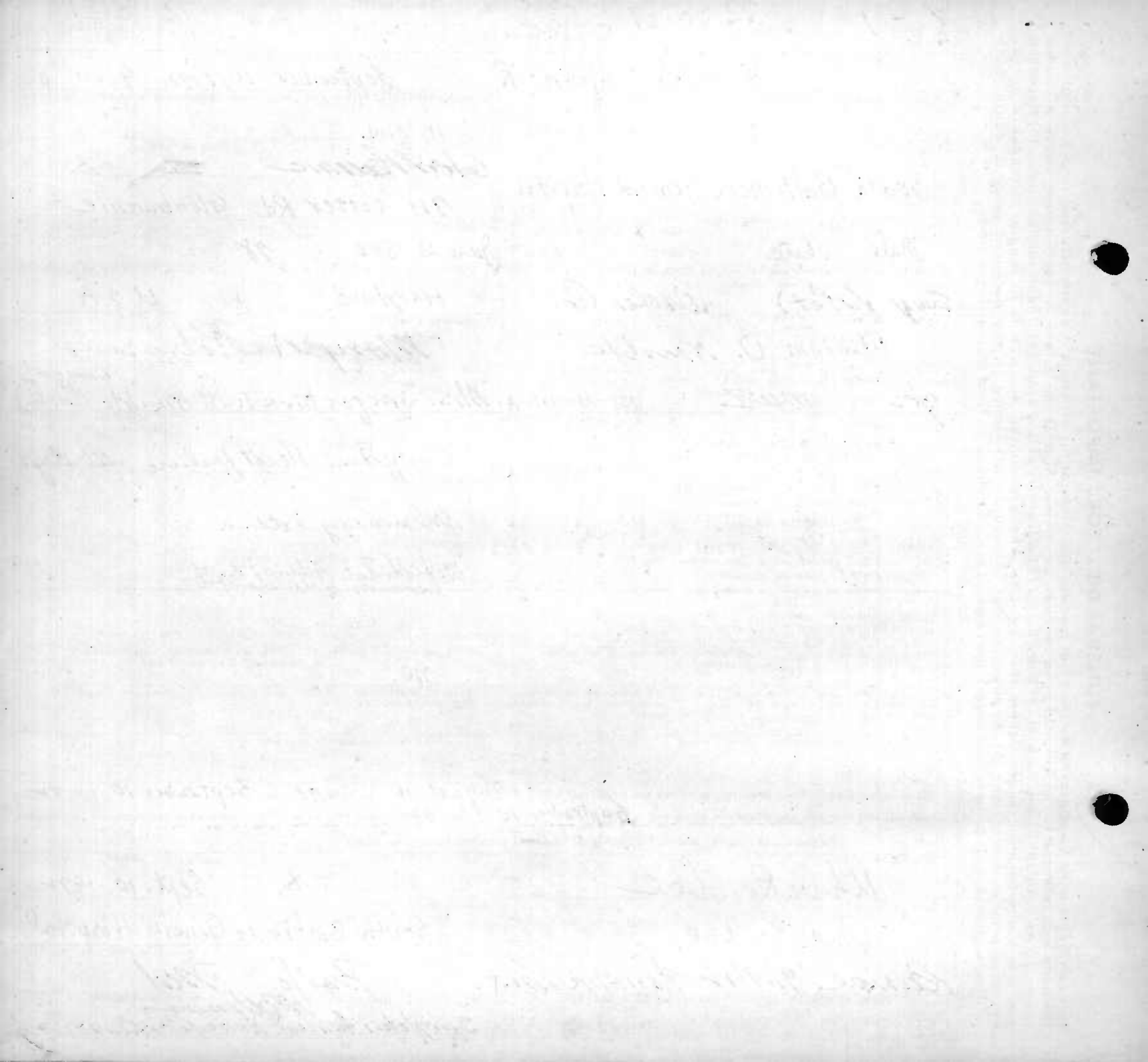


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        | REG. NO. 72 08717                                                        |                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        | STATE OF MARYLAND-DHMH                                                   |                                                                                           |
| BIRTH NO. <i>K-514</i>                                                                                                                                                                                                                                                                                                                               |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Kimble, Alvin R.</i>                                                                                              |                                                                                                                                                                                                                                        | 2. DATE AND HOUR OF DEATH<br><i>September 10, 1972 9:00 P.M.</i>         |                                                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><i>South Baltimore General Hospital</i>                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>AA</i>                                                                                                  |                                                                          |                                                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>South Baltimore General Hospital</i>                                                                                                                                                                                                 |                         |                                                                                                                                                             | C. CITY OR TOWN<br><i>Glen Burnie</i>                                                                                                                                                                                                  |                                                                          | D. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| E. STREET AND NUMBER<br><i>711 Cotter Rd. Glenburnie</i>                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        |                                                                          |                                                                                           |
| 5. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>June 23, 1894</i>                                                                                                                                                                                               | 9. AGE (in years last birthday)<br><i>78</i>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Eng (Ret)</i>                                                                                                                                                                                                                                      |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Walter Co.</i>                                                                                                      | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                                                                                                                                                                           |                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                |
| 13. FATHER'S NAME<br><i>William D. Kimble</i>                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><i>Mary R. Robinson</i>                                                                                                                                                                                    |                                                                          |                                                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>yes WWI</i>                                                                                                                                                                                                                           |                         | 16. SOCIAL SECURITY NO.<br><i>138-03-3185-A</i>                                                                                                             | 17. INFORMANT<br><i>Mrs. Jacqueline K.R. Kimble (Wife)</i>                                                                                                                                                                             |                                                                          |                                                                                           |
| 18. <i>156.1 I</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                           |                                                                          |                                                                                           |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                  |                         |                                                                                                                                                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Congestive Heart failure 45 days</i><br><br>(B) <i>Pulmonary edema</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) <i>metastatic Adenocarcinoma of common bile duct</i> |                                                                          |                                                                                           |
| II                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        |                                                                          |                                                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        |                                                                          |                                                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                               |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No)<br><i>NO.</i>                                  |                                                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                            |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                        | 21F. HOW DID INJURY OCCUR?                                               |                                                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <i>August 11 1972</i> to <i>September 10 1972</i> , that (I) (we) last saw the deceased alive on <i>September 10 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        |                                                                          |                                                                                           |
| 23A. SIGNATURE<br><i>Whun Ro. Lee</i>                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        | 23B. DATE SIGNED<br><i>Sept. 10, 1972</i>                                |                                                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Whun Ro. LEE</i>                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        | 23D. ADDRESS<br><i>South Baltimore General Hospital</i>                  |                                                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                             |                         | 24B. DATE                                                                                                                                                   |                                                                                                                                                                                                                                        | 24C. NAME OF CEMETERY or CREMATORY                                       |                                                                                           |
| <i>Burial</i>                                                                                                                                                                                                                                                                                                                                        |                         | <i>9/13/72</i>                                                                                                                                              |                                                                                                                                                                                                                                        | <i>Notre Dame Park</i>                                                   |                                                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 13 1972</i>                                                                                                                                                                                                                                                                                                |                         | 25B. NAME OF REGISTRAR<br><i>Alvin R. Kimble</i>                                                                                                            |                                                                                                                                                                                                                                        | 25C. FUNERAL DIRECTOR<br><i>W. J. Simpson</i>                            |                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                                                                                                                                                                                                        | ADDRESS<br><i>Singleton Funeral Home, Glen Burnie, Md.</i>               |                                                                                           |



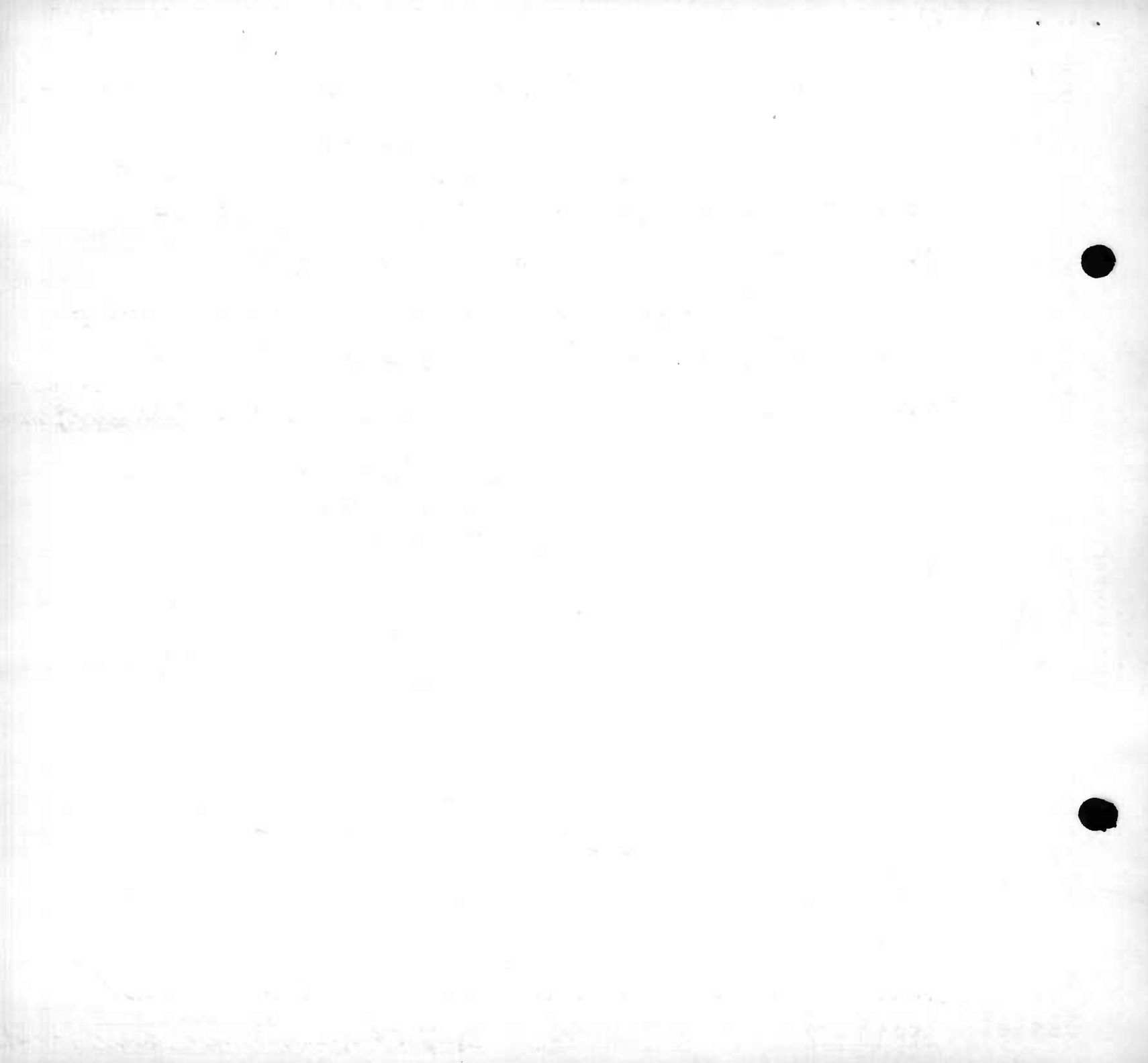




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

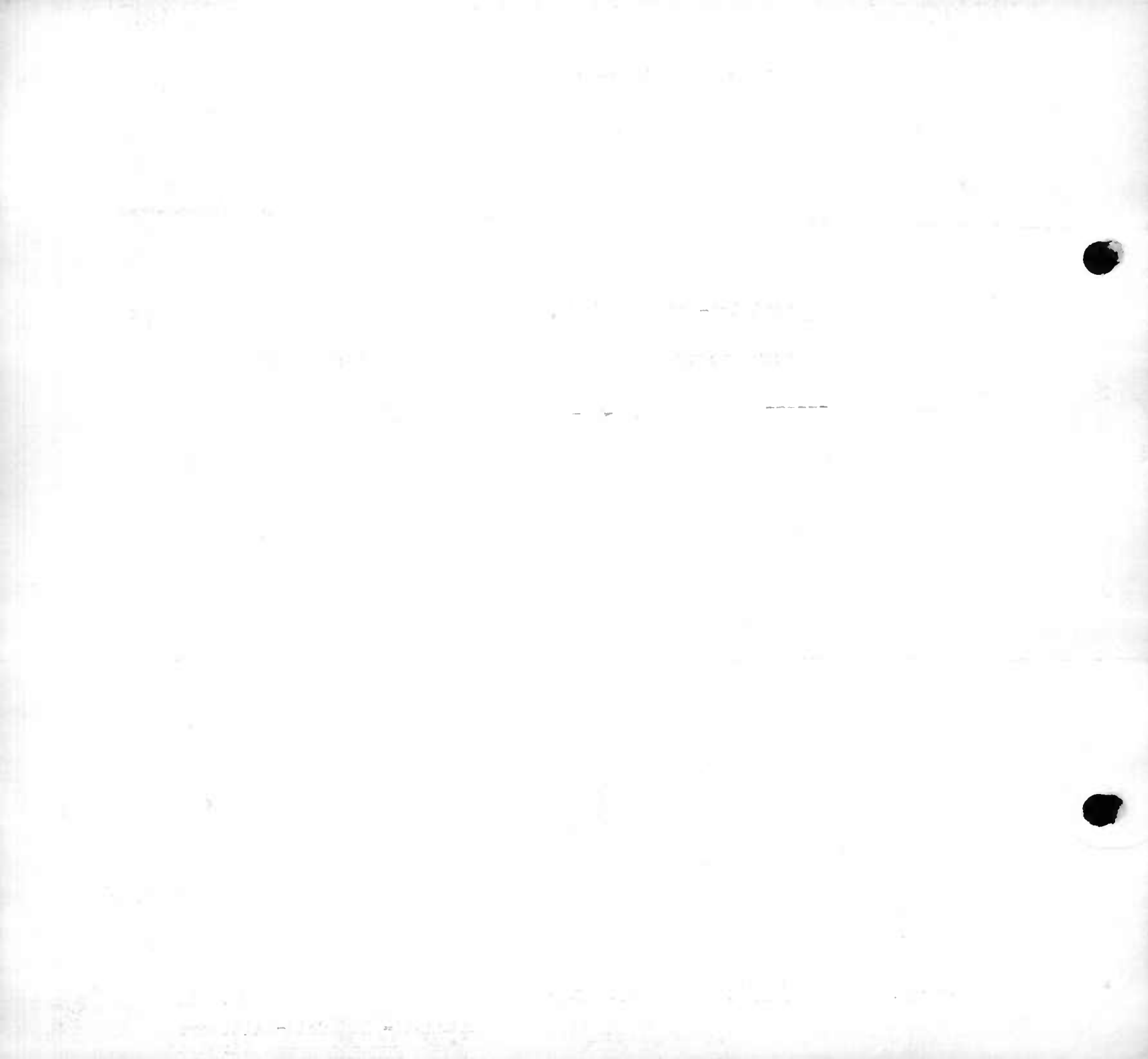
|                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                                                                                                      |                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                          |                     | REG. NO. <b>72 08718</b>                                                                                                                                                                                                             |                                                   |
| BIRTH NO. <b>W-325</b>                                                                                                                                                                                                                                                                                                                                                   |                     | DATE AND HOUR OF DEATH <b>9/10/72 7:35 A.M.</b>                                                                                                                                                                                      |                                                   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Watchman George H. Jr.</b>                                                                                                                                                                                                                                                                                                     |                     | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                            |                                                   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                                                                                |                                                   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Key Circle Hospice</b><br><b>1214 EUTAW PL. 21217</b>                                                                                                                                                                                                                                                                         |                     | A. STATE <b>Maryland</b><br>B. COUNTY <b>802</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1846 N. Gay Street</b> |                                                   |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                          | 6. RACE <b>Wht.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                          | 8. DATE OF BIRTH <b>7-1-1908</b>                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>                                                                                                                                                                                                                                                          |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Toppers Co.</b>                                                                                                                                                                              | 9. AGE (in years last birthday) <b>64</b>         |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                  |                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                        |                                                   |
| 13. FATHER'S NAME<br><b>George H. Watchman Sr.</b>                                                                                                                                                                                                                                                                                                                       |                     | 14. MOTHER'S MAIDEN NAME<br><b>Mary Luchloff</b>                                                                                                                                                                                     |                                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>None</b>                                                                                                                                                                                                                                                  |                     | 16. SOCIAL SECURITY NO.<br><b>215-05-5580 A</b>                                                                                                                                                                                      | 17. INFORMANT<br><b>Mr. Frederick L. Watchman</b> |
| 18. <b>1460 I</b>                                                                                                                                                                                                                                                                                                                                                        |                     | ADDRESS <b>25 Kent</b>                                                                                                                                                                                                               |                                                   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                           |                     | CAUSE OF DEATH                                                                                                                                                                                                                       |                                                   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                           |                     | (A) IMMEDIATE CAUSE <b>Severe disorder</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Carcinoma - Tongue with metastasis</b>                                                                                                           |                                                   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                   |                     | (B) <b>Retastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                             |                                                   |
| 19A. DATE OF OPERATION <b>9/5</b>                                                                                                                                                                                                                                                                                                                                        |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                     |                                                   |
| 20A. AUTOPSY? (Yes or No) <b>No</b>                                                                                                                                                                                                                                                                                                                                      |                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                 |                                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                           |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                             |                                                   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                 |                     | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                            |                                                   |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                        |                     | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                           |                                                   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> 19 <b>72</b> to <b>9/10</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/10</b> 19 <b>72</b> and that (in my) <b>(my)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death. |                     |                                                                                                                                                                                                                                      |                                                   |
| 23A. SIGNATURE<br><b>Helen Rompage</b>                                                                                                                                                                                                                                                                                                                                   |                     | 23B. DATE SIGNED<br><b>9/11/72</b>                                                                                                                                                                                                   |                                                   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROLEND M. SABAUNDAY</b>                                                                                                                                                                                                                                                                                                               |                     | 23D. ADDRESS<br><b>1010 St Paul Baltimore 21202</b>                                                                                                                                                                                  |                                                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                |                     | 24B. DATE<br><b>9-13-72</b>                                                                                                                                                                                                          |                                                   |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                   |                     | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                                                                                                                                                                   |                                                   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                    |                     | 25B. NAME OF REGISTRAR<br><b>...</b>                                                                                                                                                                                                 |                                                   |
| 25C. FUNERAL DIRECTOR<br><b>...</b>                                                                                                                                                                                                                                                                                                                                      |                     | ADDRESS<br><b>...</b>                                                                                                                                                                                                                |                                                   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

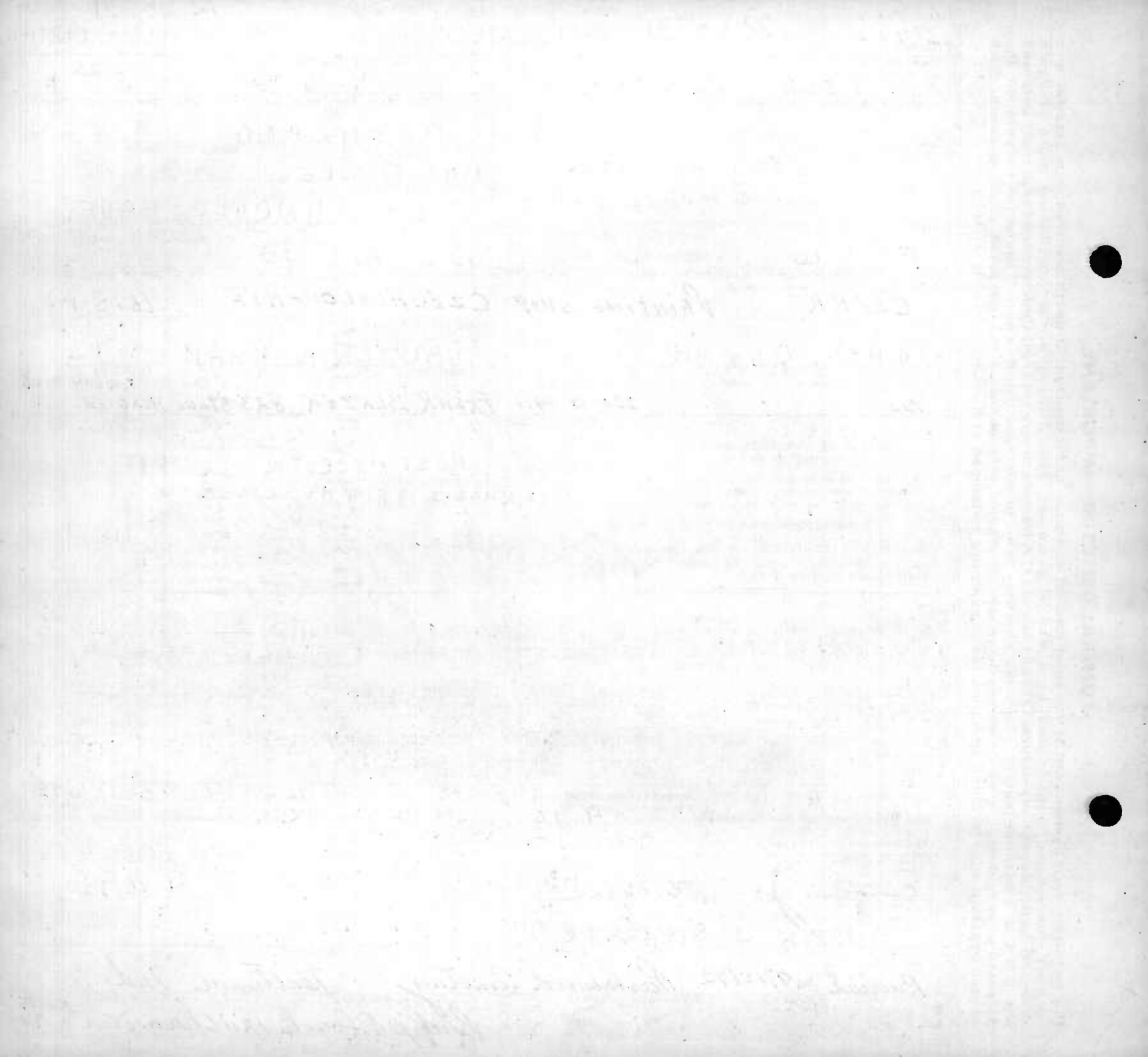
|                                                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                                                                                                                                                                                                               |                                    |                                                                          |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                |                  | 72 08719                                                                                                                                                                                                                                                                                                                                      |                                    | 72 08719                                                                 |                                                             |
| BIRTH NO. 1-200                                                                                                                                                                                                                                                                                                                                 |                  | 72 08719                                                                                                                                                                                                                                                                                                                                      |                                    | REG. NO. 72 08719                                                        |                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LACKEY CARROLL ROBERT LACKEY</b>                                                                                                                                                                                                                                                                      |                  | 2. DATE AND HOUR OF DEATH<br><b>9/17/72 8:25 AM</b>                                                                                                                                                                                                                                                                                           |                                    |                                                                          |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SOOTH BALT. GEN. HOSP.</b>                                                                                                                                                                                                             |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>PRINCE GEORGES</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>35 Dunkirk Rd Balt. MD.</b> |                                    |                                                                          |                                                             |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                 | 6. RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                   | 8. DATE OF BIRTH<br><b>10-7-02</b> | 9. AGE (in years last birthday)<br><b>69</b>                             | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Machinist-Beth Steel Co.</b>                                                                                                                                                                                                          |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                             |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>VA.</b>                  |                                                             |
| 13. FATHER'S NAME<br><b>Oscar Lackey</b>                                                                                                                                                                                                                                                                                                        |                  | 14. MOTHER'S MAIDEN NAME<br><b>Doc. Lena Smith</b>                                                                                                                                                                                                                                                                                            |                                    |                                                                          |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                           |                  | 16. SOCIAL SECURITY NO.<br><b>219-03-1178</b>                                                                                                                                                                                                                                                                                                 |                                    | 17. INFORMANT <b>wife</b> ADDRESS <b>same</b>                            |                                                             |
| 18. <b>41241</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CORONARY ARREST</b>                                                                                                     |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                           |                                    |                                                                          |                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                  |                  | (B) <b>CHF, A.F.B. in ASOD</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                             |                                    |                                                                          |                                                             |
| (C)                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                                                                                                                                                                                                               |                                    |                                                                          |                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                          |                  |                                                                                                                                                                                                                                                                                                                                               |                                    |                                                                          |                                                             |
| 19A. DATE OF OPERATION<br><b>9/17/72</b>                                                                                                                                                                                                                                                                                                        |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                              |                                    | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> NO         |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                           |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                      |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                             |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>9/17/72 8:25</b>                                                                                                                                                                                                                                                             |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                     |                                    | 21F. HOW DID INJURY OCCUR?                                               |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/16/72</b> 19 to <b>9/17/72</b> 19<br>that (I) (we) last saw the deceased alive on <b>9/17/72</b> at <b>8:15</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                                                                                                                                                                                                               |                                    |                                                                          |                                                             |
| 23A. SIGNATURE<br><b>Carroll N. Patalinghug</b>                                                                                                                                                                                                                                                                                                 |                  | 23B. DATE SIGNED<br><b>9/17/72</b>                                                                                                                                                                                                                                                                                                            |                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>CARLOS N. PATALINGHUG</b>             |                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                       |                  | 24B. DATE<br><b>9/11/72</b>                                                                                                                                                                                                                                                                                                                   |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>ROSELAND CEMETERY</b>           |                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                           |                  | 25B. NAME OF REGISTRAR<br><b>Linda H. H. H.</b>                                                                                                                                                                                                                                                                                               |                                    | 25C. FUNERAL DIRECTOR<br><b>Mitchell Wiedefeld-Baltimore</b>             |                                                             |
| VS 150-REV. 1/1/68                                                                                                                                                                                                                                                                                                                              |                  | JONES FUNERAL HOME                                                                                                                                                                                                                                                                                                                            |                                    | Virginia                                                                 |                                                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                         |  |  |  | 72 08720                                                                                               |  | 12 08720                                                                                                            |  | REG. NO. 72 08720                                                        |  | STATE OF MARYLAND-DHMH |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|------------------------|--|
| BIRTH NO. <b>B-422</b>                                                                                                                                                                                                                                                                                                   |  |  |  |                                                                                                        |  | 1. NAME OF DECEASED<br>(Type or Print) <b>TENA BLAZEK</b>                                                           |  |                                                                          |  |                        |  |
| 2. DATE AND HOUR OF DEATH<br><b>9.10.72</b>                                                                                                                                                                                                                                                                              |  |  |  |                                                                                                        |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>37 MERCY HOSPITAL<br/>301 ST. PAUL PLACE</b>           |  |                                                                          |  |                        |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>841</b>                                                                                                                                                                                |  |  |  |                                                                                                        |  | 5. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                                                          |  |                        |  |
| E. STREET AND NUMBER <b>3164 LYNDALE AVE.</b>                                                                                                                                                                                                                                                                            |  |  |  |                                                                                                        |  | 6. RACE <b>W</b>                                                                                                    |  |                                                                          |  |                        |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                              |  |  |  |                                                                                                        |  | 8. DATE OF BIRTH <b>10.20.96</b>                                                                                    |  |                                                                          |  |                        |  |
| 9. AGE (In years last birthday) <b>75</b>                                                                                                                                                                                                                                                                                |  |  |  |                                                                                                        |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>             |  |                                                                          |  |                        |  |
| 11. BIRTHPLACE (State or foreign country) <b>CZECHOSLOVAKIA</b>                                                                                                                                                                                                                                                          |  |  |  |                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                          |  |                                                                          |  |                        |  |
| 13. FATHER'S NAME <b>JOHN CERNIK</b>                                                                                                                                                                                                                                                                                     |  |  |  |                                                                                                        |  | 14. MOTHER'S MAIDEN NAME <b>ANTONIA RAK</b>                                                                         |  |                                                                          |  |                        |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>                                                                                                                                                                                                       |  |  |  |                                                                                                        |  | 16. SOCIAL SECURITY NO. <b>220-35-9911</b>                                                                          |  |                                                                          |  |                        |  |
| 17. INFORMANT <b>FRANK BLAZEK</b>                                                                                                                                                                                                                                                                                        |  |  |  |                                                                                                        |  | ADDRESS <b>823 STAGS-HEAD Rd. TOWSON, 77XL.</b>                                                                     |  |                                                                          |  |                        |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                        |  |                                                                                                                     |  |                                                                          |  |                        |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                           |  |  |  |                                                                                                        |  |                                                                                                                     |  |                                                                          |  |                        |  |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                         |  |  |  |                                                                                                        |  |                                                                                                                     |  |                                                                          |  |                        |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                        |  |  |  |                                                                                                        |  |                                                                                                                     |  |                                                                          |  |                        |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                |  |  |  |                                                                                                        |  |                                                                                                                     |  |                                                                          |  |                        |  |
| II                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                        |  |                                                                                                                     |  |                                                                          |  |                        |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                         |  |  |  |                                                                                                        |  |                                                                                                                     |  |                                                                          |  |                        |  |
| 19A. DATE OF OPERATION <b>9.12.72</b>                                                                                                                                                                                                                                                                                    |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                     |  | 20A. AUTOPSY? (Yes or No)                                                |  |                        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                           |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  |                                                                                                                     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |                        |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                |  |  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |                                                                                                                     |  | 21F. HOW DID INJURY OCCUR?                                               |  |                        |  |
| 22. I certify that (a) (this hospital) attended the deceased from <b>8.10.72</b> to <b>9.10.72</b> , that (b) (we) last saw the deceased alive on <b>9.10.72</b> and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (We) (did) (did not) view the body after death. |  |  |  |                                                                                                        |  |                                                                                                                     |  |                                                                          |  |                        |  |
| 23A. SIGNATURE <b>Eugene J. Strasser MD</b>                                                                                                                                                                                                                                                                              |  |  |  |                                                                                                        |  |                                                                                                                     |  | 23B. DATE SIGNED <b>9.18.72</b>                                          |  |                        |  |
| 23C. PHYSICIAN'S NAME (Type) <b>EUGENE J. STRASSER MD</b>                                                                                                                                                                                                                                                                |  |  |  |                                                                                                        |  |                                                                                                                     |  | 23D. ADDRESS                                                             |  |                        |  |
| 24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                    |  |  |  | 24B. DATE <b>9/12/72</b>                                                                               |  |                                                                                                                     |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>              |  |                        |  |
| 24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>                                                                                                                                                                                                                                                               |  |  |  | 24E. (State) <b>Balto</b>                                                                              |  |                                                                                                                     |  | 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 13 1972</b>                       |  |                        |  |
| 25B. NAME OF REGISTRAR <b>Philip E. Frach</b>                                                                                                                                                                                                                                                                            |  |  |  | 25C. FUNERAL DIRECTOR <b>1211 Chesaco Ave</b>                                                          |  |                                                                                                                     |  | 25D. ADDRESS <b>37</b>                                                   |  |                        |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                             |  |                                                                                                                                  |  |                                                                                                                                                          |  |                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| G-620                                                                                                                                       |  | 72 08721                                                                                                                         |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                         |  | 72 08721                                                             |  |
| BIRTH NO.                                                                                                                                   |  | 72 08721                                                                                                                         |  | CERTIFICATE OF DEATH                                                                                                                                     |  | REG. NO. 72 08721                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                      |  | George, John K.                                                                                                                  |  | 2. DATE AND HOUR OF DEATH                                                                                                                                |  | Sept 6, 1972 6:25 A.M.                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                      |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                            |  | A. STATE                                                                                                                                                 |  | B. COUNTY                                                            |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                        |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                             |  | Md.                                                                                                                                                      |  | Anne Arundel                                                         |  |
| 4940 Eastern Ave, Baltimore, Md.                                                                                                            |  | Baltimore City Hospital                                                                                                          |  | 21224                                                                                                                                                    |  | 21144                                                                |  |
| 5. SEX                                                                                                                                      |  | 6. RACE                                                                                                                          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>                                                                    |  | 8. DATE OF BIRTH                                                     |  |
| Male                                                                                                                                        |  | Caucasian                                                                                                                        |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                       |  | March 13, 1944                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                 |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                |  | 12. CITIZEN OF WHAT COUNTRY?                                         |  |
| Student                                                                                                                                     |  |                                                                                                                                  |  | Maryland                                                                                                                                                 |  | U.S.A.                                                               |  |
| 13. FATHER'S NAME                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME                                                                                                         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                 |  | 16. SOCIAL SECURITY NO.                                              |  |
| James Kermit Georg.                                                                                                                         |  | Piper BARBARA M.                                                                                                                 |  | No                                                                                                                                                       |  | Records: BCH 4940 Eastern Ave. 21224                                 |  |
| 18. 232.11                                                                                                                                  |  | CAUSE OF DEATH                                                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |                                                                      |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                              |  | (A) IMMEDIATE CAUSE                                                                                                              |  | RESPIRATORY ARREST                                                                                                                                       |  |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) |  | DUE TO, OR AS A CONSEQUENCE OF:                                                                                                  |  | E BRAIN DAMAGE                                                                                                                                           |  |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                           |  | (B) SEVERE RENAL FAILURE IN HEMODIALYSIS                                                                                         |  | DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                          |  |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last                                    |  | (C) CONGENITAL HYPOPARATHYROIDISM                                                                                                |  |                                                                                                                                                          |  |                                                                      |  |
| II                                                                                                                                          |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | BRAIN DAMAGE 2° to PREVIOUS CARDIO-RESPIRATORY ARREST                                                                                                    |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                         |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |  |                                                                      |  |
| 21D. TIME OF INJURY (Approx.)                                                                                                               |  | 21E. INJURY OCCURRED                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 14 1972 to SEPT 6 1972                                               |  | that (I) (we) last saw the deceased alive on SEPT 6 1972                                                                         |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                              |  | 23B. DATE SIGNED                                                                                                                 |  | 23C. PHYSICIAN'S NAME (Type)                                                                                                                             |  | 23D. ADDRESS                                                         |  |
| E. Contreras                                                                                                                                |  | 9-6-1972                                                                                                                         |  | E. CONTRERAS                                                                                                                                             |  | 4940 Eastern Ave. Baltimore, Md. 21224                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                    |  | 24B. DATE                                                                                                                        |  | 24C. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 24D. LOCATION                                                        |  |
| BURIAL                                                                                                                                      |  | 9/9/72                                                                                                                           |  | Glen Haven Mem Park                                                                                                                                      |  | GLEN BURNIE, MD                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                             |  | 25B. NAME OF REGISTRAR                                                                                                           |  | 25C. FUNERAL DIRECTOR                                                                                                                                    |  | ADDRESS                                                              |  |
| SEP 13 1972                                                                                                                                 |  | Audrey W. Weston                                                                                                                 |  | Harold J. FH, 172 West St.                                                                                                                               |  | ANNAPOLIS, MD 21403                                                  |  |





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

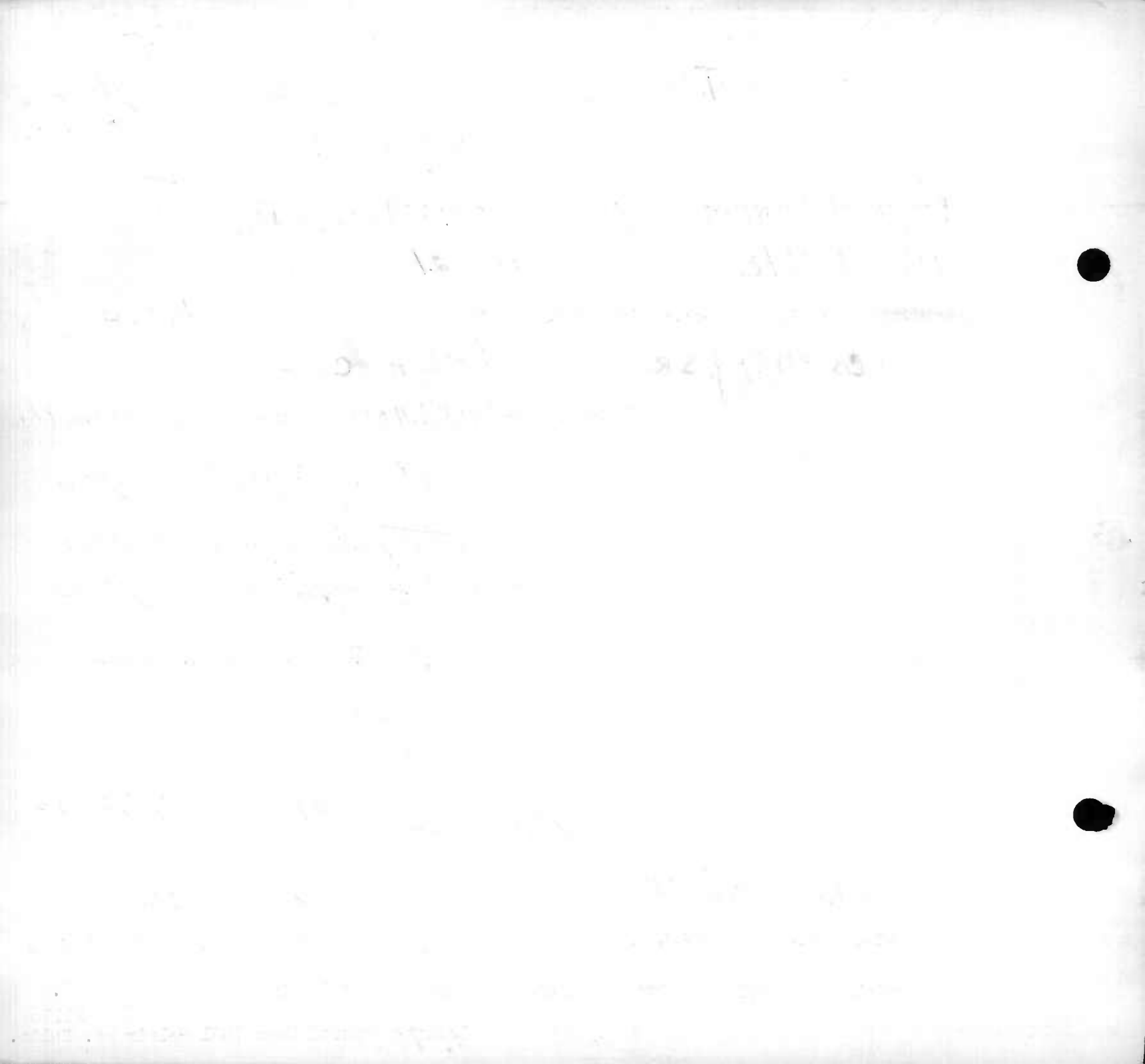
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                              |         |                                                                                                          |                  | REG. NO. <span style="float: right;">72 08722</span>                     |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| BIRTH NO. <span style="float: right;">H-560</span>                                                                                                                                                                                                                                                                                                            |         |                                                                                                          |                  | 72 08722 CERTIFICATE OF DEATH                                            |                                                                                            |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                        |         | 2. DATE AND HOUR OF DEATH                                                                                |                  | STATE OF MARYLAND - DEMO                                                 |                                                                                            |
| STEPHAN HEINER                                                                                                                                                                                                                                                                                                                                                |         | SEPT 8 1972                                                                                              |                  | 6:30 A M.                                                                |                                                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                        |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                    |                  |                                                                          |                                                                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                     |         | A. STATE B. COUNTY                                                                                       |                  |                                                                          |                                                                                            |
| 00 232 S DURHAM ST                                                                                                                                                                                                                                                                                                                                            |         | MARYLAND 202                                                                                             |                  |                                                                          |                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                               |         | C. CITY OR TOWN                                                                                          |                  | D. INSIDE CITY LIMITS?                                                   |                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                               |         | BALTIMORE                                                                                                |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                               |         | E. STREET AND NUMBER                                                                                     |                  |                                                                          |                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                               |         | 232 S DURHAM STREET                                                                                      |                  |                                                                          |                                                                                            |
| 5. SEX                                                                                                                                                                                                                                                                                                                                                        | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                          | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| MALE                                                                                                                                                                                                                                                                                                                                                          | WHITE   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                       | DEC 6 1898       | 73                                                                       | TOOL MAKER                                                                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                   |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                        |                  | 11. BIRTHPLACE (State or foreign country)                                |                                                                                            |
| TOOL MAKER                                                                                                                                                                                                                                                                                                                                                    |         | GLOBE MACHINE CO                                                                                         |                  | SCRANTON PA                                                              |                                                                                            |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                  |         | 13. FATHER'S NAME                                                                                        |                  |                                                                          |                                                                                            |
| U.S.A.                                                                                                                                                                                                                                                                                                                                                        |         | JOHN HEINER                                                                                              |                  |                                                                          |                                                                                            |
| 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                      |         | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |                  |                                                                          |                                                                                            |
| ANASTASIA PAULOV <del>HEINER</del>                                                                                                                                                                                                                                                                                                                            |         | NO -                                                                                                     |                  |                                                                          |                                                                                            |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                       |         | 17. INFORMANT ADDRESS                                                                                    |                  |                                                                          |                                                                                            |
| 161-07-80434                                                                                                                                                                                                                                                                                                                                                  |         | MYRTLE HEINER 232 S DURHAM ST                                                                            |                  |                                                                          |                                                                                            |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                            |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |                  |                                                                          |                                                                                            |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                |         | Cancer of lung                                                                                           |                  |                                                                          |                                                                                            |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                  |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                      |                  |                                                                          |                                                                                            |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                             |         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                      |                  |                                                                          |                                                                                            |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                     |         | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                      |                  |                                                                          |                                                                                            |
| II                                                                                                                                                                                                                                                                                                                                                            |         |                                                                                                          |                  |                                                                          |                                                                                            |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                              |         |                                                                                                          |                  |                                                                          |                                                                                            |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                         |                  | 20A. AUTOPSY? (Yes or No)                                                |                                                                                            |
| 7/24/72                                                                                                                                                                                                                                                                                                                                                       |         | Cancer of lung                                                                                           |                  | NO                                                                       |                                                                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                         |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                 |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                          |                  |                                                                          |                                                                                            |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                 |         | 21E. INJURY OCCURRED                                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                               |                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                               |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                        |                  |                                                                          |                                                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Jul 23</u> 19 <u>72</u> to <u>Aug 31</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>Aug 31</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |         |                                                                                                          |                  |                                                                          |                                                                                            |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                                                |         |                                                                                                          |                  | 23B. DATE SIGNED                                                         |                                                                                            |
| <u>[Signature]</u> MD                                                                                                                                                                                                                                                                                                                                         |         |                                                                                                          |                  | 9/9/72                                                                   |                                                                                            |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                  |         |                                                                                                          |                  | 23D. ADDRESS                                                             |                                                                                            |
| JH ZIMMERMAN MD                                                                                                                                                                                                                                                                                                                                               |         |                                                                                                          |                  | 100 N. BROADWAY 21731                                                    |                                                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                      |         | 24B. DATE                                                                                                |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |                                                                                            |
| CREMATION                                                                                                                                                                                                                                                                                                                                                     |         | SEPT 9-72                                                                                                |                  | SECURITY PROCESS INC                                                     |                                                                                            |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                 |         | 25A. DATE REC'D BY HEALTH DEPT.                                                                          |                  |                                                                          |                                                                                            |
| 301 FREDERICK RD MD                                                                                                                                                                                                                                                                                                                                           |         | SEP 13 1972                                                                                              |                  |                                                                          |                                                                                            |
| 25B. NAME OF REGISTRAR                                                                                                                                                                                                                                                                                                                                        |         | 25C. FUNERAL DIRECTOR                                                                                    |                  | ADDRESS                                                                  |                                                                                            |
| Sidney [Signature]                                                                                                                                                                                                                                                                                                                                            |         | DIPPEL BROS INC                                                                                          |                  | 1800 E LOMBARD ST                                                        |                                                                                            |

NO  
14-07-8033A WHITE HEIMER 335 2 DURHAM ST  
JOHN HEIMER  
TOTAL WORKER GLOBE MACHINE CO. STANTON PA  
MALE WHITE  
✓  
335 2 DURHAM ST  
BATHMORE  
MARK LIND  
DEC 8 1988 73  
335 2 DURHAM STREET  
U.S.A.  
ANASTASIA PAVLOV

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                  |  |                                                                                          |  |                                                                                                                                                             |  |                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                 |  | 72 08723                                                                                 |  | REG. NO. 359                                                                                                                                                |  | 72 08723                                                                                      |  |
| BIRTH NO. D-100                                                                                                                                                                                                                                                  |  |                                                                                          |  | CERTIFICATE OF DEATH                                                                                                                                        |  |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) JOSEPH T. DUFFY                                                                                                                                                                                                           |  |                                                                                          |  | 2. DATE AND HOUR OF DEATH<br>9/10/72 9:00 A.M.                                                                                                              |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>PARK HILL NURSING HOME                                                                                                                                                                                 |  |                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY 2735                                |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                             |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                     |  | C. CITY OR TOWN<br>BALTIMORE                                                                                                                                |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX<br>M                                                                                                                                                                                                                                                      |  | 6. RACE<br>White                                                                         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br>2/21/1891                                                                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Clerk                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Balto City Police Dept                              |  | 9. AGE (In years lost birthday)<br>81                                                                                                                       |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND                                         |  |
| 13. FATHER'S NAME<br>FRANCIS DUFFY, SR.                                                                                                                                                                                                                          |  | 14. MOTHER'S MAIDEN NAME<br>DELIA CUFFE                                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                      |  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                |  | 16. SOCIAL SECURITY NO.<br>215-01-6885-A                                                 |  | 17. INFORMANT<br>PARK HILL NURSING HOME                                                                                                                     |  | ADDRESS<br>1802 Eytaw Pl.                                                                     |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>4/23/1<br>arteriosclerotic heart disease |  |                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years                                                                                                       |  |                                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>arteriosclerotic general<br>chronic bronchitis                                                                                 |  |                                                                                          |  | DUE TO, OR AS A CONSEQUENCE OF:<br>(B) years<br>(C) years                                                                                                   |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                           |  |                                                                                          |  |                                                                                                                                                             |  |                                                                                               |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                           |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                            |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |                                                                                               |  |
| 21D. TIME OF INJURY (Specify)                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to 9/10/72                                                                                                                                                                                |  | that (I) (we) last saw the deceased alive on 9/10/72                                     |  | and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.    |  |                                                                                               |  |
| 23A. SIGNATURE<br>[Signature]                                                                                                                                                                                                                                    |  |                                                                                          |  | 23B. DATE SIGNED<br>9/11/72                                                                                                                                 |  |                                                                                               |  |
| 23C. PHYSICIAN'S NAME (Type)<br>ANLAN H. MACHET                                                                                                                                                                                                                  |  |                                                                                          |  | 23D. ADDRESS<br>2620 N. ST BALTIMORE                                                                                                                        |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                               |  | 24B. DATE<br>9/12/72                                                                     |  | 24C. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                                                                                                |  | 24D. LOCATION<br>Baltimore Md.                                                                |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR<br>[Signature]                                                    |  | 25C. FUNERAL DIRECTOR<br>Lassan Funeral Home                                                                                                                |  | ADDRESS 21236<br>7401 Belair Rd. Balto.                                                       |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08724

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Earl Serena</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 9 7 72 10:22A. M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>31 Baltimore City Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 7 72 10:22A. M.                                                                       |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7. RACE<br>White                                                                                                                          |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | C. CITY OR TOWN<br>Baltimore                                                                                                              |  |
| 9. DATE OF BIRTH<br>8/24/26                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (In years lost birthday) 46                                                                                                       |  |
| 11. BIRTHPLACE (State or foreign country)<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                       |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>TRUCK DRIVER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>TRUCKING                                                                                             |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>LARKIES WWII                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 17. SOCIAL SECURITY NO.<br>216-20-6006                                                                                                    |  |
| 18. INFORMANT<br>MARGIE SERENA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS<br>ABOVE                                                                                                                          |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Multiple injuries<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                              |  |
| 20A. DATE OF OPERATION<br>2/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  |
| 21. AUTOPSY? (Yes or No)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street                                        |  |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?<br>4500 blk. Eastern Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22D. TIME (Month) (Day) (Year) (Hour)<br>7 8 72 1:40A. M.                                                                                 |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22F. HOW DID INJURY OCCUR?<br>Pedestrian struck by truck                                                                                  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>W P Mulloy</b> M.D.<br>EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br>9-8-72 |  |                                                                                                                                           |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br>9/11/72                                                                                                                      |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>PARKWOOD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 24D. LOCATION (City, town, or county) (State)<br>BALTO. MD.                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br>Sidney Whitton                                                                                                  |  |
| 25C. FUNERAL DIRECTOR<br>J. B. CONNELLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br>300 MACE                                                                                                                       |  |

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains many important points. The President begins by expressing his pleasure in being able to take the oath of office, and then he goes on to discuss the state of the Union. He mentions the recent election, and he expresses his confidence in the new Congress. He also discusses the state of the country, and he mentions the recent war with Mexico. The letter is a very important document, and it is one of the most important documents in the history of the United States.

2. The second part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains many important points. The President begins by expressing his pleasure in being able to take the oath of office, and then he goes on to discuss the state of the Union. He mentions the recent election, and he expresses his confidence in the new Congress. He also discusses the state of the country, and he mentions the recent war with Mexico. The letter is a very important document, and it is one of the most important documents in the history of the United States.

3. The third part of the document is a letter from the President to the Congress, dated January 1, 1861. It is a very important document, as it is the first official communication of the new President to the new Congress. The letter is written in a very formal and dignified style, and it contains many important points. The President begins by expressing his pleasure in being able to take the oath of office, and then he goes on to discuss the state of the Union. He mentions the recent election, and he expresses his confidence in the new Congress. He also discusses the state of the country, and he mentions the recent war with Mexico. The letter is a very important document, and it is one of the most important documents in the history of the United States.

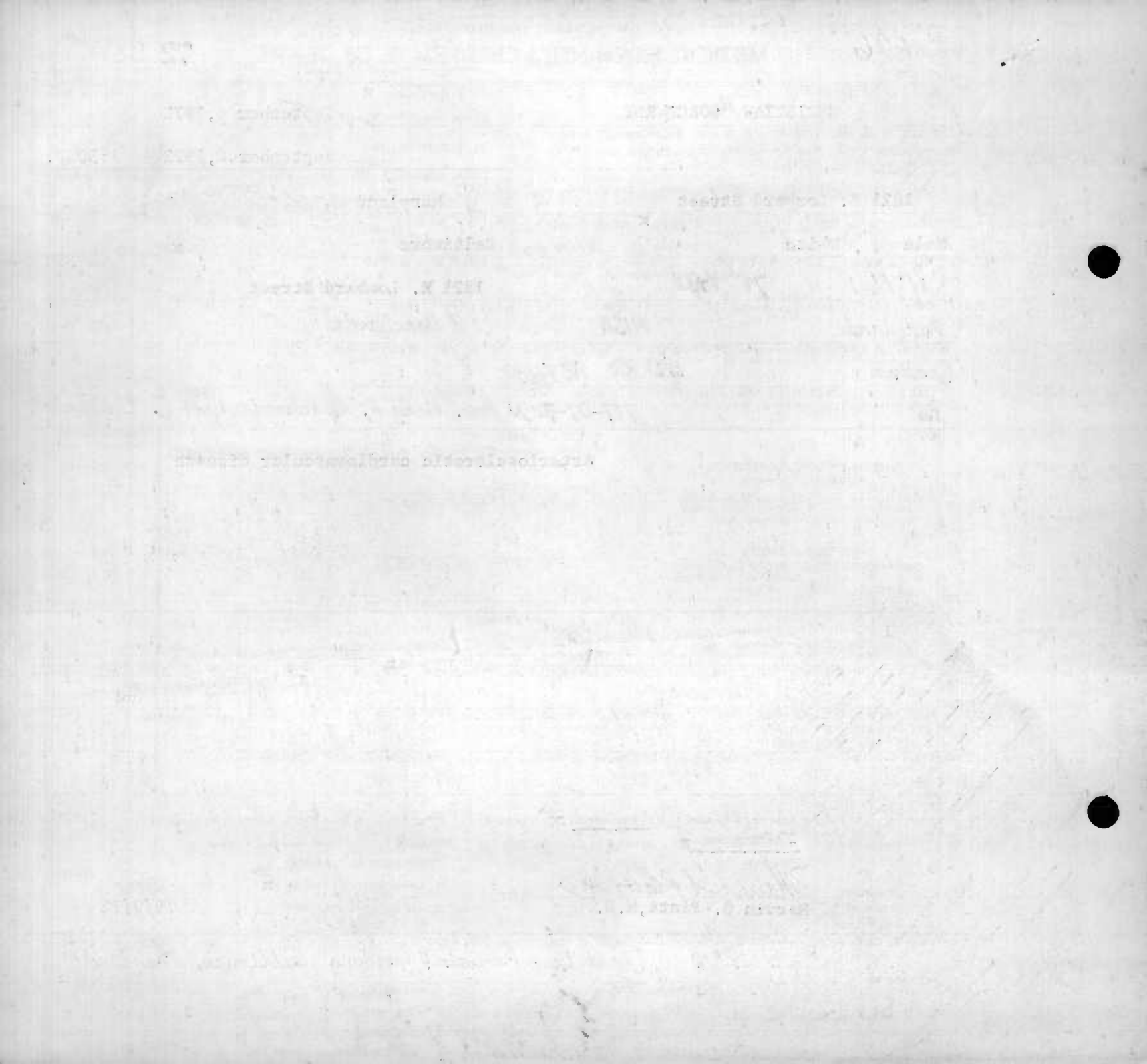
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CHRISTIAN # BORCHARDT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> <b>September 8, 1972</b> M.              |                                                                                     |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1821 E. Lombard Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 8, 1972 1:30 P.M.</b>                                                                        |                                                                                     |
| 5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                     |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 7. RACE<br><b>White</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN<br><b>Baltimore</b>                                                 |
| 9. DATE OF BIRTH<br><b>1/2/01</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 10. AGE (In years last birthday) <b>71</b> <del>70</del><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                          | E. STREET AND NUMBER<br><b>1821 E. Lombard Street</b>                               |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 12. CITIZEN OF<br><b>USA</b>                                                                                                                                | 13. FATHER'S NAME<br><b>? Borchardt</b>                                             |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Crewman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O RR A854732</b>                                                                                              | 15. MOTHER'S MAIDEN NAME<br><b>?</b>                                                |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 17. SOCIAL SECURITY NO.<br><b>717-07-1250</b>                                                                                                               | 18. INFORMANT<br><b>Mrs. Mary E. Borchardt</b> ADDRESS<br><b>1821 E. Lombard St</b> |
| 19. <b>712.4</b><br>CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).          |                         |                                                                                                                                                             |                                                                                     |
| 20A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                     |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                     |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                   |                                                                                     |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 22F. HOW DID INJURY OCCUR?                                                                                                                                  |                                                                                     |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>9/9/72</b> |                         |                                                                                                                                                             |                                                                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 24B. DATE<br><b>9/11/72</b>                                                                                                                                 |                                                                                     |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Crest Lawn Memorial Gardens</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                 |                                                                                     |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 25B. NAME OF REGISTRAR<br><b>Arday Whitton</b>                                                                                                              |                                                                                     |
| 25C. FUNERAL DIRECTOR<br><b>John P. Moran, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | ADDRESS<br><b>3000 E. Baltimore St.</b>                                                                                                                     |                                                                                     |



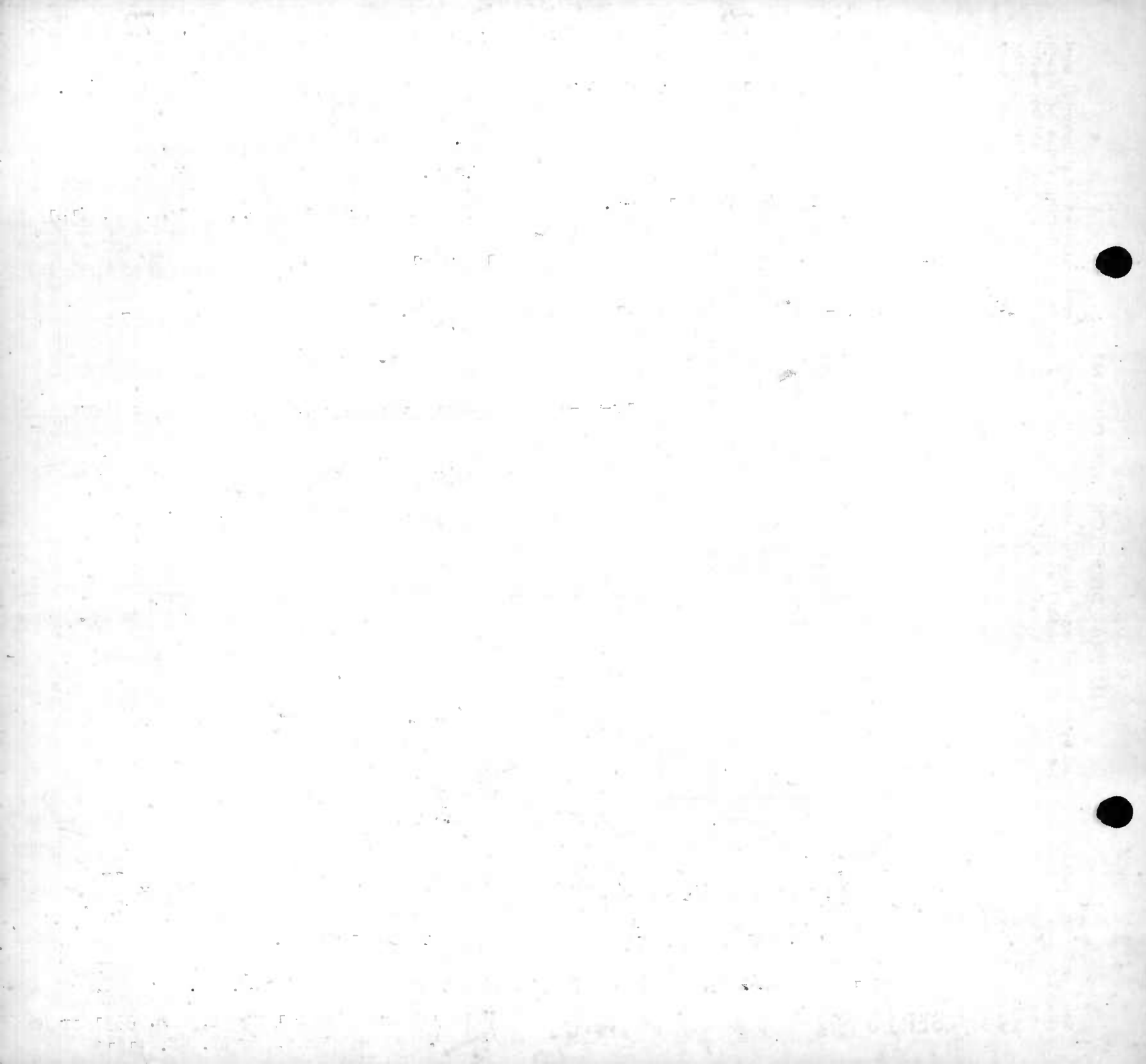




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                          | REG. NO. <u>72 08726</u>                                                        |                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <p><u>7623</u></p> <p>BIRTH NO.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | <p><u>72 08726</u> <b>CERTIFICATE OF DEATH</b></p>                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                          |                                                                                 |                                                                                |
| <p>1. NAME OF DECEASED<br/>(Type or Print)</p> <p style="text-align: center;"><u>Milton Forrester</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                                     | <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;"><u>9/6/72</u> <u>2 A.</u> M.</p>                                                                                                                                                                                                                                                         |                                                                                 |                                                                                |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;"><u>00</u> <u>2809 Chesterfield Ave.</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                                     | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>Md.</u> B. COUNTY <u>831</u></p> <p>C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>2809 Chesterfield Ave., Balto. Md. 21213</u></p> |                                                                                 |                                                                                |
| <p>5. SEX <u>M</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>6. RACE <u>W</u></p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>12/20/07</u></p>                                                                                                                                                                                                                                                                                                                  | <p>9. AGE (In years last birthday) <u>70</u></p>                                | <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>               |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Test desk - retired</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                     | <p>10B. KIND OF BUSINESS OR INDUSTRY <u>C &amp; P Telephone Co</u></p>                                                                                                                                                                                                                                                                                   |                                                                                 |                                                                                |
| <p>11. BIRTHPLACE (State or foreign country) <u>Md.</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                                     | <p>12. CITIZEN OF WHAT COUNTRY? <u></u></p>                                                                                                                                                                                                                                                                                                              |                                                                                 |                                                                                |
| <p>13. FATHER'S NAME <u>Harry Forrester</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                                     | <p>14. MOTHER'S MAIDEN NAME <u>Clara Metzger</u></p>                                                                                                                                                                                                                                                                                                     |                                                                                 |                                                                                |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="text-align: center;"><u>no</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                                     | <p>16. SOCIAL SECURITY NO. <u>27-05-0428</u></p>                                                                                                                                                                                                                                                                                                         |                                                                                 | <p>17. INFORMANT <u>Anne Forrester (wife)</u> ADDRESS <u>same as above</u></p> |
| <p>18. <u>348.0 I</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>myotrophic lateral sclerosis</u></p> <p style="text-align: center;">(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Primary Spinomuscular atrophy</u></p> <p style="text-align: center;">(C) <u></u></p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> |                         |                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                          |                                                                                 |                                                                                |
| <p>19A. DATE OF OPERATION <u>0</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>                                                                                                             |                                                                                                                                                                                                                                                                                                                                                          | <p>20A. AUTOPSY? (Yes or No) <u>No</u></p>                                      |                                                                                |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                     |                                                                                                                                                                                                                                                                                                                                                          | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> |                                                                                |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                       |                                                                                                                                                                                                                                                                                                                                                          | <p>21F. HOW DID INJURY OCCUR?</p>                                               |                                                                                |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> 19<u>69</u> to <u>9/6</u> 19<u>72</u>, that (I) (we) lost saw the deceased alive on <u>9/5</u> 19<u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                          |                                                                                 |                                                                                |
| <p>23A. SIGNATURE <u>[Signature]</u> DEGREE</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                          | <p>23B. DATE SIGNED <u>9/8/72</u></p>                                           |                                                                                |
| <p>23C. PHYSICIAN'S NAME (Type) <u>Dr. Sol Tannenbaum</u> DEGREE</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                          | <p>23D. ADDRESS <u>5508 Belair Rd.</u></p>                                      |                                                                                |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | <p>24B. DATE <u>9/9/72</u></p>                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                          | <p>24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u></p>      |                                                                                |
| <p>24D. LOCATION <u>Balto. Md.</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | <p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1972</u></p>                                                                                                           |                                                                                                                                                                                                                                                                                                                                                          |                                                                                 |                                                                                |
| <p>25B. NAME OF REGISTRAR <u>[Signature]</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | <p>25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u> ADDRESS <u>3337 Brehms Lane, Balto. Md. 21213</u></p>                                                 |                                                                                                                                                                                                                                                                                                                                                          | <p>25D. <u>04722</u></p>                                                        |                                                                                |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| S-350                                                                                                                                                                                                                                                                                            |         | 72 08727                                                                                 |                  | BALTIMORE CITY HEALTH DEPT.                                                                                                     |                            | 72 08727                                                             |                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------|-----------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                             |         |                                                                                          |                  | REG. NO.                                                                                                                        |                            |                                                                      |                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                        |         | 1. NAME OF DECEASED<br>(Type or Print)                                                   |                  | 2. DATE AND HOUR OF DEATH                                                                                                       |                            | STATE OF MARYLAND - DHMH                                             |                             |
|                                                                                                                                                                                                                                                                                                  |         | Sutton, Wm. E.                                                                           |                  | 9.8.72                                                                                                                          |                            | 1 05 P.M.                                                            |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                           |         |                                                                                          |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                           |                            |                                                                      |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                     |         |                                                                                          |                  | A. STATE B. COUNTY                                                                                                              |                            |                                                                      |                             |
| 37 Mercy Hospital                                                                                                                                                                                                                                                                                |         |                                                                                          |                  | MARYLAND 2642                                                                                                                   |                            |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  | C. CITY OR TOWN                                                                                                                 |                            | D. INSIDE CITY LIMITS?                                               |                             |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  | BALTIMORE                                                                                                                       |                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                             |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  | E. STREET AND NUMBER                                                                                                            |                            |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  | 4217 MORAVIA Rd 21206                                                                                                           |                            |                                                                      |                             |
| 5. SEX                                                                                                                                                                                                                                                                                           | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                                                                                 | If Under 1 Yr. Months Days |                                                                      | If Under 24 Hrs. Hours Min. |
| MALE                                                                                                                                                                                                                                                                                             | WHITE   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 11/20/98         | 73                                                                                                                              |                            |                                                                      |                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                      |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                  | 11. BIRTHPLACE (State or foreign country)                                                                                       |                            | 12. CITIZEN OF WHAT COUNTRY?                                         |                             |
| Pipe Fitter                                                                                                                                                                                                                                                                                      |         | Heir Bros.                                                                               |                  | Md.                                                                                                                             |                            | -                                                                    |                             |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                |         |                                                                                          |                  | 14. MOTHER'S MAIDEN NAME                                                                                                        |                            |                                                                      |                             |
| Thomas Sutton                                                                                                                                                                                                                                                                                    |         |                                                                                          |                  | Mollie O'Halloran                                                                                                               |                            |                                                                      |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                         |         | 16. SOCIAL SECURITY NO.                                                                  |                  | 17. INFORMANT                                                                                                                   |                            | ADDRESS                                                              |                             |
| no                                                                                                                                                                                                                                                                                               |         | 220-03-9259                                                                              |                  | Alice Sutton (wife)                                                                                                             |                            | same as above                                                        |                             |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                               |         |                                                                                          |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                    |                            |                                                                      |                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                   |         |                                                                                          |                  | hours                                                                                                                           |                            |                                                                      |                             |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                     |         |                                                                                          |                  | Pulmonary Emboli                                                                                                                |                            |                                                                      |                             |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                |         |                                                                                          |                  | Generalized Intravascular Coagulopathy                                                                                          |                            |                                                                      |                             |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                        |         |                                                                                          |                  | 24 hr.                                                                                                                          |                            |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  | Carcinoma of Lung                                                                                                               |                            |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  | 1/2 year                                                                                                                        |                            |                                                                      |                             |
| II                                                                                                                                                                                                                                                                                               |         |                                                                                          |                  | years                                                                                                                           |                            |                                                                      |                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                 |         |                                                                                          |                  | Chronic Obstructive Lung Disease                                                                                                |                            |                                                                      |                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                           |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                                                                       |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |
| 2                                                                                                                                                                                                                                                                                                |         |                                                                                          |                  | YES                                                                                                                             |                            | YES                                                                  |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                            |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                        |                            |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  |                                                                                                                                 |                            |                                                                      |                             |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                    |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                                                                                      |                            |                                                                      |                             |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                      |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |                                                                                                                                 |                            |                                                                      |                             |
| 22. I certify that (I) (this hospital) attended the deceased from 9-1-72 to 9-8-72, that (I) (we) last saw the deceased alive on 9-8-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                                                                                 |                            |                                                                      |                             |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                   |         |                                                                                          |                  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                            | 23B. DATE SIGNED                                                     |                             |
| Shelly H. Moore                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  |                                                                                                                                 |                            | 9-8-72                                                               |                             |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                     |         |                                                                                          |                  | 23D. ADDRESS                                                                                                                    |                            |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  |                                                                                                                                 |                            |                                                                      |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                         |         | 24B. DATE                                                                                |                  | 24C. NAME of CEMETERY or CREMATORY                                                                                              |                            | 24D. LOCATION (City, town, or county) (State)                        |                             |
| Burial                                                                                                                                                                                                                                                                                           |         | 9/12/72                                                                                  |                  | Gardens of Faith Cemetery                                                                                                       |                            | Balto. Md.                                                           |                             |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                  |         | 25B. NAME OF FUNERAL DIRECTOR                                                            |                  | 25C. FUNERAL DIRECTOR ADDRESS                                                                                                   |                            |                                                                      |                             |
| SEP 13 1972                                                                                                                                                                                                                                                                                      |         | Shelly H. Moore                                                                          |                  | Schamunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213                                                                |                            |                                                                      |                             |

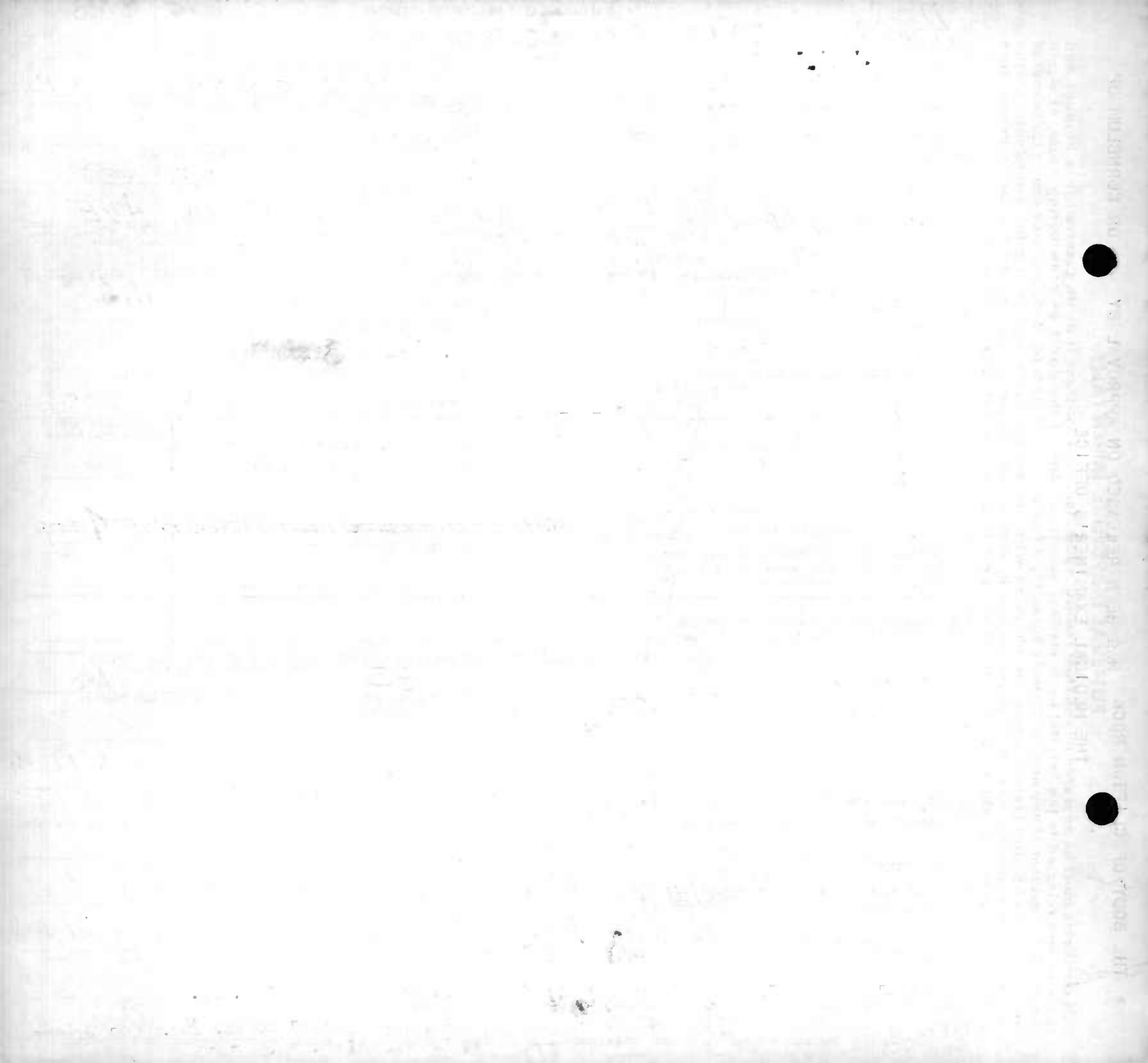
Plumage  
Color of  
Bill  
Length of  
Tarsus  
Crown  
Yes

9-11-11  
9-11-11

Alfred W. Brown

This certificate must be approved by the MEDICAL EXAMINER'S OFFICE. THE MEDICAL EXAMINER'S OFFICE has approved this certificate. The body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

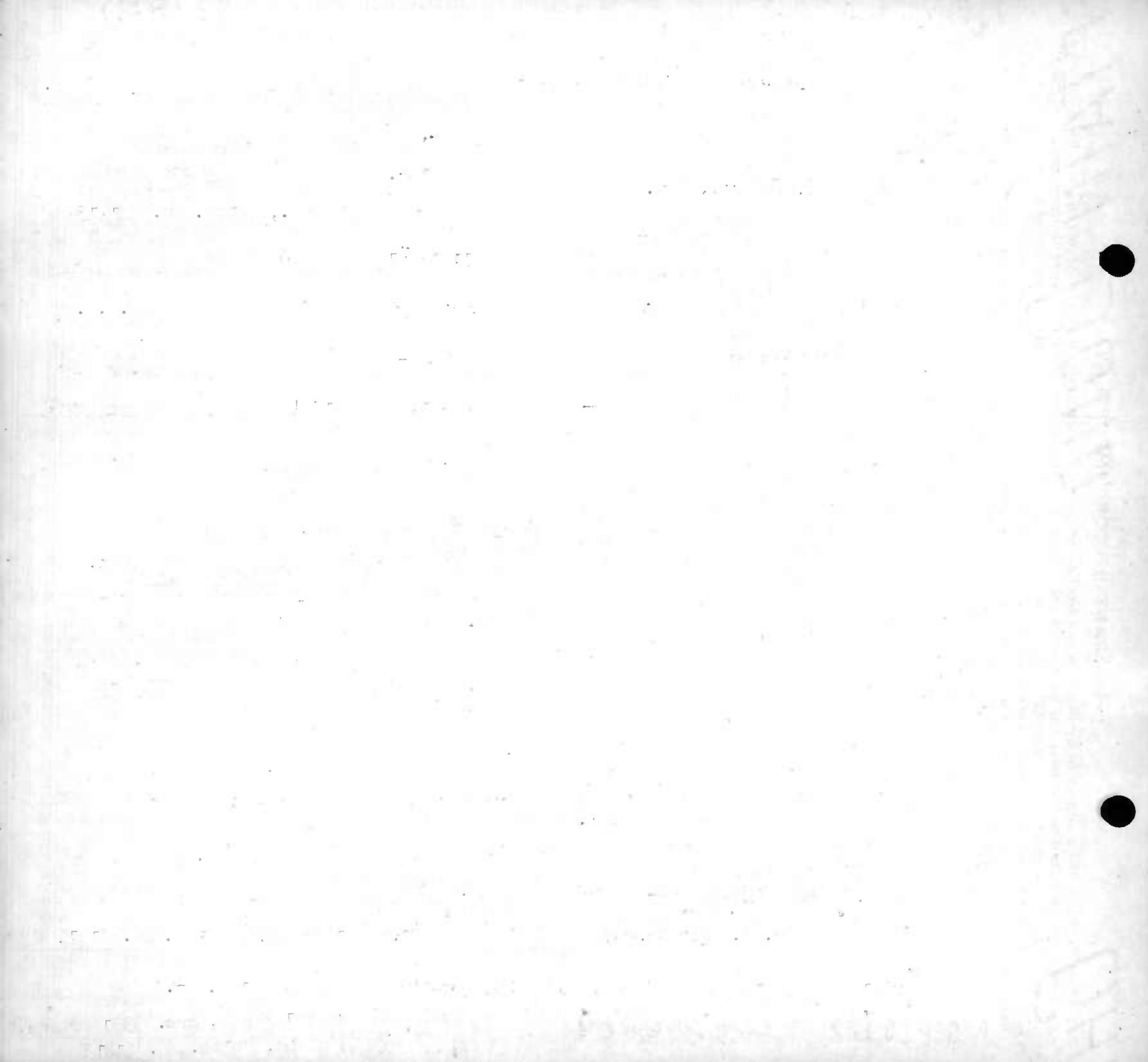
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |                                    |                                                                                                                                        |                                                                    |                                                                                               |                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------|
| A-200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 72 08728                                                                                                                                                    |                                    | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                       |                                                                    | 12 08728                                                                                      |                                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |                                    | REG. NO.                                                                                                                               |                                                                    |                                                                                               |                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Paul CLIFTON ROCK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |                                    | 2. DATE AND HOUR OF DEATH<br><b>9/9/72 8:58 PM</b>                                                                                     |                                                                    |                                                                                               |                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>702</b> |                                                                    |                                                                                               |                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Johns Hopkins Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |                                    | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                    |                                                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                             |
| ADDRESS OR LOCATION<br><b>Baltimore, Md 21205</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |                                    | E. STREET AND NUMBER<br><b>610 N. Kenwood AVE</b>                                                                                      |                                                                    |                                                                                               |                                             |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/23/53</b> | 9. AGE (in years last birthday)<br><b>19</b>                                                                                           | If Under 1 Yr. Months Days                                         | If Under 24 Hrs. Hours Min.                                                                   |                                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY  |                                                                                                                                        | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, Md.</b> |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |
| 13. FATHER'S NAME<br><b>HERMAN Rock</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                    | 14. MOTHER'S MAIDEN NAME<br><b>F. JOAN Clifton</b>                                                                                     |                                                                    |                                                                                               |                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |                                    | 16. SOCIAL SECURITY NO.<br><b>217-62-6172</b>                                                                                          |                                                                    | 17. INFORMANT<br><b>FATHER</b>                                                                |                                             |
| 18. <b>304.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Intravenous Narcotics (Levorphanol)</b><br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>CARDIAC ARREST</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>NARCOTIC OVERDOSE (Levorphanol)</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>4 days</b><br>(C)<br><b>20 minutes</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                     |                                                                                                                                                             |                                    |                                                                                                                                        |                                                                    |                                                                                               |                                             |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |                                    |                                                                                                                                        |                                                                    |                                                                                               |                                             |
| 19A. DATE OF OPERATION<br><b>2. None</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY (Yes or No)<br><b>YES</b>                                                                                                 |                                                                    | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>No</b>             |                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>Natural</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>IB</b>                                                       |                                    | 21C. WHERE DID INJURY OCCUR<br>(If in Baltimore City, give exact location)                                                             |                                                                    |                                                                                               |                                             |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?<br><b>Injected Levorphanol - Natural death</b>                                                              |                                                                    |                                                                                               |                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/3/72</b> 19 <b>72</b> to <b>9/9</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/9</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |                                    |                                                                                                                                        |                                                                    |                                                                                               |                                             |
| 23A. SIGNATURE<br><b>J. Raymond DePaulo Jr MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |                                    | 23B. DATE SIGNED<br><b>9/9/72</b>                                                                                                      |                                                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>J. Raymond DePaulo Jr MD</b>                               |                                             |
| 23D. ADDRESS<br><b>Johns Hopkins Hospital Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                    | 23E. MED. DIRECTOR <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>     |                                                                    |                                                                                               |                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | 24B. DATE<br><b>9/13/72</b>                                                                                                                                 |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Gardens of Faith Cemetery</b>                                                                 |                                                                    | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                            |                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | 25B. NAME OF REGISTRAR<br><b>Andrew...</b>                                                                                                                  |                                    | 25C. FUNERAL DIRECTOR<br><b>Schimunek Funeral Homes, Inc.</b>                                                                          |                                                                    | ADDRESS<br><b>3337 Brehms Lane 2 Balto. Md. 21213</b>                                         |                                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                         |                                                                                                                                                                                                                                                                                                      |                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>G-643</span> <span>72 08729</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         | BALTIMORE CITY HEALTH DEPARTMENT<br>REG. NO. 72 08729<br><b>STATE OF MARYLAND-DEME</b>                                                                                                                                                                                                               |                                                          |
| BIRTH NO. 1. NAME OF DECEASED (Type or Print)<br><div style="text-align: center;">Margaret Marie Gerhold</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | 2. DATE AND HOUR OF DEATH<br><div style="text-align: center;">9/9/72 10:00 P. M.</div>                                                                                                                                                                                                               |                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><div style="text-align: center;">3205 Ramona Ave.</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 2633<br>C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 3205 Ramona Ave., Balto. Md. 21213 |                                                          |
| 5. SEX F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. RACE W                               | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                          | 8. DATE OF BIRTH 11/19/91                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         | 10B. KIND OF BUSINESS OR INDUSTRY<br>at home                                                                                                                                                                                                                                                         | 9. AGE (In years lost birthday) 80                       |
| 13. FATHER'S NAME Henry Becker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | 11. BIRTHPLACE (State or foreign country) Germany                                                                                                                                                                                                                                                    |                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                                                                                                                                                                                  |                                                          |
| 16. SOCIAL SECURITY NO. none                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         | 14. MOTHER'S MAIDEN NAME -                                                                                                                                                                                                                                                                           |                                                          |
| 17. INFORMANT Charles Gerhold (husband)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         | ADDRESS same as above                                                                                                                                                                                                                                                                                |                                                          |
| 18. 412.2 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? - |                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 da<br>10 yrs -                                                                                                                                                                                                                                     |                                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -                                                                                                                                                                                                           |                                                          |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -                                                                                                                                                                                                                                          |                                                          |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         | 21F. HOW DID INJURY OCCUR? -                                                                                                                                                                                                                                                                         |                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from February 1971 to Sept - 9 1972, that (I) (we) last saw the deceased alive on Sept - 9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                               |                                         |                                                                                                                                                                                                                                                                                                      |                                                          |
| 23A. SIGNATURE Dr. J. Duer Moores M.D. DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         | 23B. DATE SIGNED 9-11-72                                                                                                                                                                                                                                                                             |                                                          |
| 23C. PHYSICIAN'S NAME (Type) Dr. J. Duer Moores DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         | 23D. ADDRESS 3105 Belair Road, Balto. Md. 21213                                                                                                                                                                                                                                                      |                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 24B. DATE 9/13/72                       | 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery                                                                                                                                                                                                                                         | 24D. LOCATION (City, town, or county) (State) Balto. Md. |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 25B. NAME OF REGISTRAR Sidney H. Heston | 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213                                                                                                                                                                                                       |                                                          |

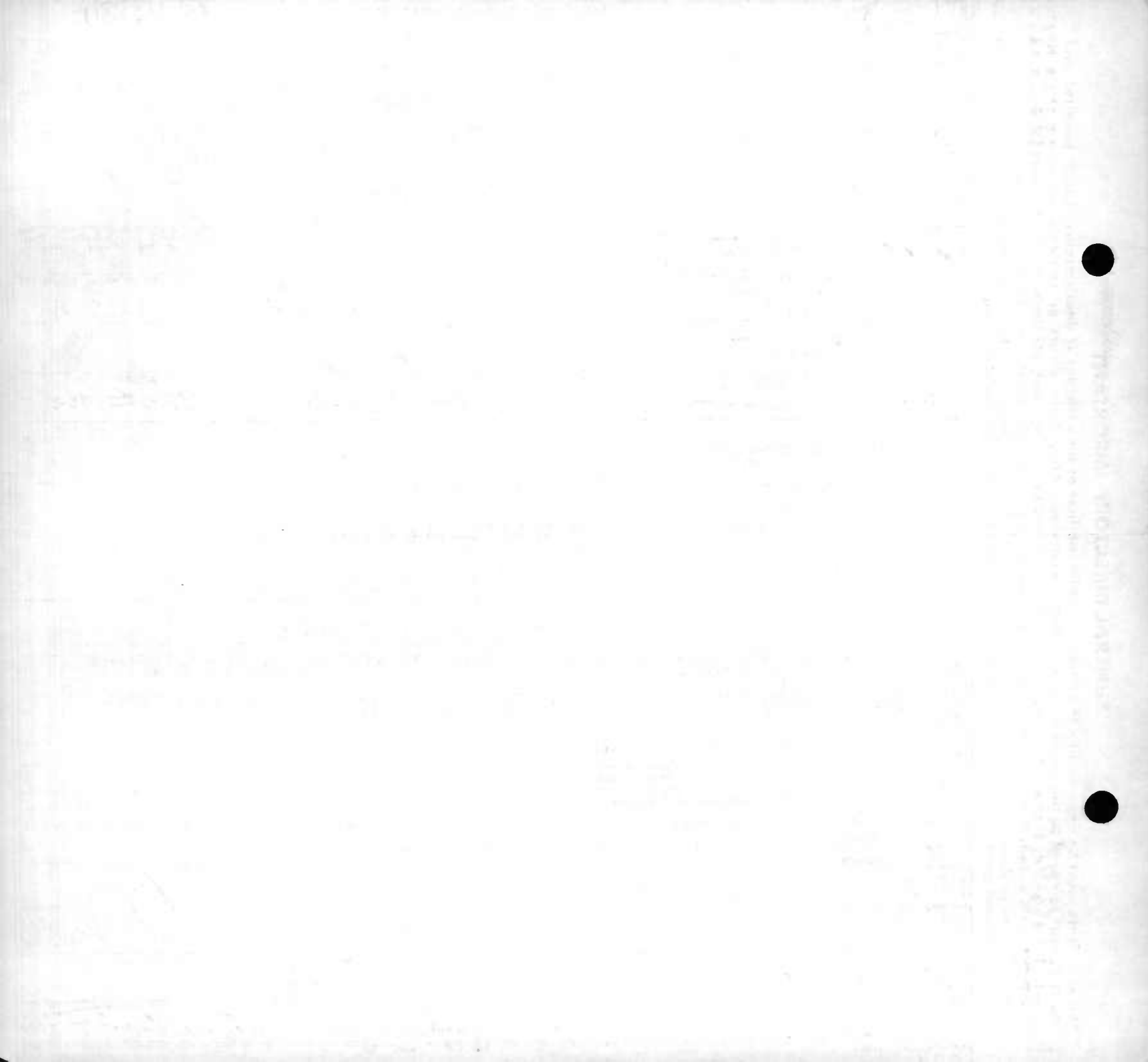




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

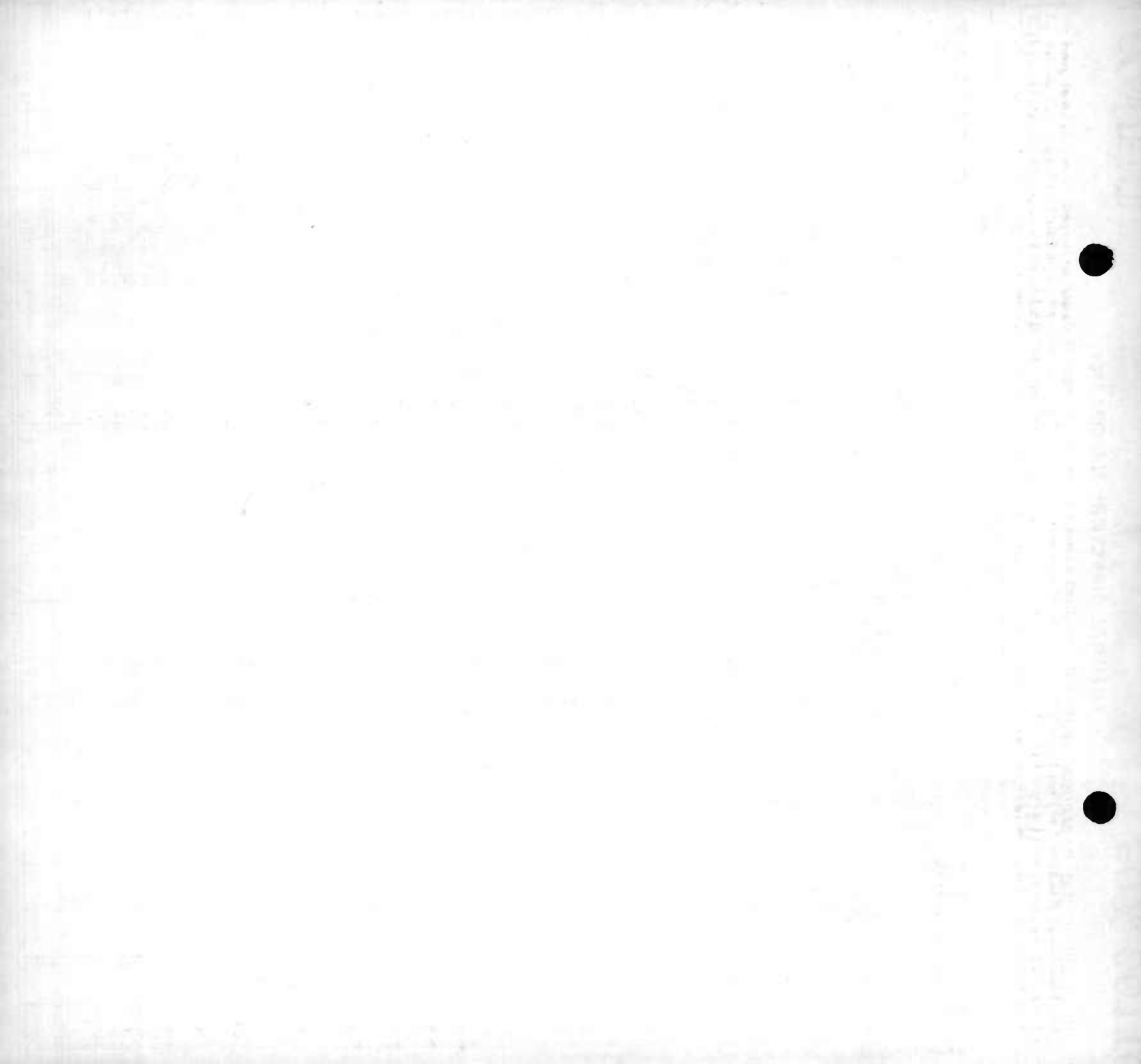
|                                                                                                                                                                                                                                                                                     |  |                                                                                            |  |                                                                                       |  |                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| J-520                                                                                                                                                                                                                                                                               |  | 72 08730                                                                                   |  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |  | REG. NO. 72 08730                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                           |  | 1. NAME OF DECEASED<br>(Type or Print)                                                     |  | 2. DATE AND HOUR OF DEATH                                                             |  | STATE OF MARYLAND-DHMH                                               |  |
|                                                                                                                                                                                                                                                                                     |  | Jones, Roberta L.                                                                          |  | 9/11/72                                                                               |  | 10:50 AM.                                                            |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                              |  |                                                                                            |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                       |  | A. STATE                                                                              |  | B. COUNTY                                                            |  |
| Maryland General Hospital                                                                                                                                                                                                                                                           |  |                                                                                            |  | 3412 Beech Ave. Balto, Md. 21211                                                      |  |                                                                      |  |
| 48                                                                                                                                                                                                                                                                                  |  |                                                                                            |  | C. CITY OR TOWN                                                                       |  | D. INSIDE CITY LIMITS?                                               |  |
|                                                                                                                                                                                                                                                                                     |  |                                                                                            |  | Baltimore                                                                             |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX                                                                                                                                                                                                                                                                              |  | 6. RACE                                                                                    |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>            |  | 8. DATE OF BIRTH                                                     |  |
| Female                                                                                                                                                                                                                                                                              |  | White                                                                                      |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 11/8/56                                                              |  |
| 9. AGE (In years last birthday)                                                                                                                                                                                                                                                     |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  | 11. BIRTHPLACE (State or foreign country)                                             |  | 12. CITIZEN OF WHAT COUNTRY?                                         |  |
| 15                                                                                                                                                                                                                                                                                  |  | Student                                                                                    |  | Maryland                                                                              |  | U.S.A.                                                               |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                   |  |                                                                                            |  | 14. MOTHER'S MAIDEN NAME                                                              |  |                                                                      |  |
| Ernest                                                                                                                                                                                                                                                                              |  |                                                                                            |  | Shirley                                                                               |  |                                                                      |  |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                            |  |                                                                                            |  | 16. SOCIAL SECURITY NO.                                                               |  | 17. INFORMANT ADDRESS                                                |  |
| No                                                                                                                                                                                                                                                                                  |  |                                                                                            |  |                                                                                       |  | Shirley Jones 3412 Beech Ave.                                        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                  |  |                                                                                            |  | CAUSE OF DEATH                                                                        |  |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                         |  |                                                                                            |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                   |  |                                                                                            |  | (B) ASEPTIC MENINGITIS                                                                |  |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                           |  |                                                                                            |  | (C) Diabetic Keto Acidosis → Coma                                                     |  |                                                                      |  |
| II                                                                                                                                                                                                                                                                                  |  |                                                                                            |  | SUENILE DIABETES                                                                      |  |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                    |  |                                                                                            |  |                                                                                       |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                              |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                           |  | 20A. AUTOPSY? (Yes or No)                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                     |  |                                                                                            |  |                                                                                       |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR?                                                          |  | (If in Baltimore City, give exact location)                          |  |
| 21D. TIME OF INJURY (APPROX)                                                                                                                                                                                                                                                        |  | 21E. INJURY OCCURRED                                                                       |  | 21F. HOW DID INJURY OCCUR?                                                            |  |                                                                      |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                         |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>          |  |                                                                                       |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                            |  |                                                                                       |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                      |  |                                                                                            |  | 23B. DATE SIGNED                                                                      |  |                                                                      |  |
| Victor R. FELIPA M.D.                                                                                                                                                                                                                                                               |  |                                                                                            |  | 9/11/72                                                                               |  |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                        |  |                                                                                            |  | 23D. ADDRESS                                                                          |  |                                                                      |  |
| Victor R. FELIPA M.D.                                                                                                                                                                                                                                                               |  |                                                                                            |  | Maryland General Hospital                                                             |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                            |  | 24B. DATE                                                                                  |  | 24C. NAME OF CEMETERY or CREMATORY                                                    |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                              |  | 9/14/72                                                                                    |  | Woodlawn                                                                              |  | Balto. Ind                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR                                                                     |  | 25C. FUNERAL DIRECTOR                                                                 |  | ADDRESS                                                              |  |
| SEP 13 1972                                                                                                                                                                                                                                                                         |  | Dorothy H. Hinton                                                                          |  | Paul E. Gennett                                                                       |  | 3617 Chestnut Ave                                                    |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                                                                     |                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 72 08731                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                | 72 08731                                                                            |                                                                                                                                 |
| BIRTH NO. <b>P-653</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             | <b>CERTIFICATE OF DEATH</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                | REG. NO. <b>72 08731</b>                                                            |                                                                                                                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <b>PRUNTY, CONARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>9-10-72</b> <b>3:30 AM</b>                                                                                                                                                                                                                                                                     |                                                                                     |                                                                                                                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Belvue Hospital of Baltimore, Inc.<br/>Belvue Ave at Greenspring</b>                                                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>21215</b><br>C. CITY OR TOWN <b>BALTO, MD.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>5307 HAMLIN AVE.</b> <b>2717</b> |                                                                                     |                                                                                                                                 |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. RACE<br><b>WHITE</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-28-98</b>                                                                                                                                                                                                                                                                                            | 9. AGE (In years last birthday)<br><b>73</b>                                        | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                                                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                                                                                                                                                                                                | 11. BIRTHPLACE (State or foreign country)<br><b>W. VA.</b>                          |                                                                                                                                 |
| 13. FATHER'S NAME<br><b>?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>?</b>                                                                                                                                                                                                                                                                                           |                                                                                     |                                                                                                                                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                             | 16. SOCIAL SECURITY NO.<br><b>217-01-0244</b>                                                                                                               |                                                                                                                                                                                                                                                                                                                                | 17. INFORMANT<br><b>CHARLES PRUNTY</b> ADDRESS <b>135 CHESTNUT HILL LANE W.</b>     |                                                                                                                                 |
| 18. <b>038,91</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>none</b> |                             |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hr.</b><br><b>2 d</b>                                                                                                                                                                                                                                                    |                                                                                     |                                                                                                                                 |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                | 20A. AUTOPSY? (Yes or No)                                                           |                                                                                                                                 |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)         |                                                                                                                                 |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                | 21F. HOW DID INJURY OCCUR?                                                          |                                                                                                                                 |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-9-72</b> to <b>9-10-72</b> and that (I) (we) lost saw the deceased alive on <b>9-10-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                          |                             |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                                                                     |                                                                                                                                 |
| 23A. SIGNATURE<br><b>Imvook Boonsue MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             |                                                                                                                                                             | 23B. DATE SIGNED<br><b>9-10-72</b>                                                                                                                                                                                                                                                                                             |                                                                                     | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Imvook Boonsue MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             | 23D. ADDRESS<br><b>Sumai Hospital, Balto, MD 21215</b>                                                                                                                                                                                                                                                                         |                                                                                     |                                                                                                                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 24B. DATE<br><b>9/11/72</b> | 24C. NAME of CEMETERY or CREMATORY<br><b>DRUID RIDGE</b>                                                                                                    |                                                                                                                                                                                                                                                                                                                                | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO, MD.</b>                  |                                                                                                                                 |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | 25B. NAME OF REGISTRAR<br><b>James H. ...</b>                                                                                                               |                                                                                                                                                                                                                                                                                                                                | 25C. FUNERAL DIRECTOR<br><b>PAUL G. CHENOWETH</b> ADDRESS <b>3617 CHESTNUT AVE.</b> |                                                                                                                                 |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | 72 08732                                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | STATE OF MARYLAND - DEPT. OF HEALTH                                                                                                                         |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Wells, Lewis Alexander</b>                                                                                                                                                                                                                                                                    |  | 2. DATE AND HOUR OF DEATH<br><b>Sept. 7, 1972 13:30 P.M.</b>                                              |  |                                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                     |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Univ. of Md. Hospital</b>                                                                                                                                                                                                                                                                    |  | A. STATE<br><b>Md.</b>                                                                                    |  | B. COUNTY<br><b>Calvert</b>                                                                                                                                 |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                    |  | C. CITY OR TOWN<br><b>Huntingtown</b>                                                                     |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                          |  |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                      |  | 6. RACE<br><b>W</b>                                                                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>6-4-99</b>                                                                                                                                                                                                                                                                                                       |  | 9. AGE (in years last birthday)<br><b>73</b>                                                              |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farm r</b>                                                                                                                                                                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                         |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                              |  | 13. FATHER'S NAME<br><b>William Thomas Wells</b>                                                          |  | 14. MOTHER'S MAIDEN NAME<br><b>Marian Fowler</b>                                                                                                            |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                   |  | 16. SOCIAL SECURITY NO.<br><b>213-22-0356</b>                                                             |  | 17. INFORMANT<br><b>Kenneth Wells</b>                                                                                                                       |  |
| ADDRESS<br><b>Huntingtown, Md.</b>                                                                                                                                                                                                                                                                                                      |  | 18. CAUSE OF DEATH<br><b>Myocardial infarction 3 dys.</b>                                                 |  |                                                                                                                                                             |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                     |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                       |  |                                                                                                                                                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br><b>9-7-72</b>                                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                                                                                                      |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                             |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                               |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-4-72</b> to <b>9-7-72</b> that (I) (we) last saw the deceased alive on <b>9-7-72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.                    |  |                                                                                                           |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><b>John D. Hughes</b>                                                                                                                                                                                                                                                                                                 |  | DEGREE<br><b>MD</b>                                                                                       |  | 23B. DATE SIGNED<br><b>9-7-72</b>                                                                                                                           |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                            |  | 23D. ADDRESS<br><b>Univ. of Md. Hosp.</b>                                                                 |  |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                |  | 24B. DATE<br><b>9/10/72</b>                                                                               |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Miranda Memorial</b>                                                                                               |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Huntingtown, Calvert Md.</b>                                                                                                                                                                                                                                                        |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                     |  |                                                                                                                                                             |  |
| 25B. NAME OF REGISTRAR<br><b>Anthony J. Buchanan</b>                                                                                                                                                                                                                                                                                    |  | 25C. FUNERAL DIRECTOR<br><b>Buchanan Funeral Home, Owings, Md.</b>                                        |  |                                                                                                                                                             |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| N-220. 72 08733                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |  | REG. NO. 12 00133                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH                                                                                                                                   |  |                                                                                               |  |
| RONALD J. NIJAK                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | 9/8/72 745 P.M.                                                                                                                                             |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                       |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                          |  |                                                                                                           |  | A. STATE<br>Md.                                                                                                                                             |  | B. COUNTY<br>BALTO                                                                            |  |
| SOUTH BALTIMORE GENERAL HOSPITAL                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 43                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | E. STREET AND NUMBER<br>451 Lambert Ct                                                                                                                      |  |                                                                                               |  |
| 5. SEX<br>M                                                                                                                                                                                                                                                                                                                                        |  | 6. RACE<br>White                                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>4-18-34                                                                   |  |
| 9. AGE (In years last birthday)<br>38                                                                                                                                                                                                                                                                                                              |  | 10. If Under 1 Yr. Months: Days: Hours: Min.<br>4 20                                                      |  | 11. BIRTHPLACE (State or foreign country)<br>Indiana                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Permanent disability                                                                                                                                                                                                                                |  |                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  |                                                                                               |  |
| 13. FATHER'S NAME<br>Casimir Nijak                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br>Bernice Bogucki Indiana                                                                                                         |  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Korean War                                                                                                                                                                                                                             |  |                                                                                                           |  | 16. SOCIAL SECURITY NO.<br>317-32-1458                                                                                                                      |  | 17. INFORMANT<br>Wife                                                                         |  |
| 18. 491X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                                                                                                           |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>PNEUMONIA<br>(B) CHRONIC BRONCHITIS + EMPHYSEMA<br>(C) _____                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 DAY<br>SEVERAL YEARS                        |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                               |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br>YES                                                                                                                            |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>NO                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |                                                                                               |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                          |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8/27 19 72 to 9/8 19 72, that (I) (we) last saw the deceased alive on 9/8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                         |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                               |  |
| 23A. SIGNATURE<br>Robert J. Bauer, M.D.                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | 23B. DATE SIGNED<br>9/8/72                                                                                                                                  |  | 23C. PHYSICIAN'S NAME (Type)<br>ROBERT J. BAUER, M.D.                                         |  |
| 23D. ADDRESS<br>3001 S. HANOVER ST. BALT., MD.                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                          |  |                                                                                               |  |
| 24B. DATE<br>9/13/72                                                                                                                                                                                                                                                                                                                               |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Glen Haven                                                          |  | 24D. LOCATION (City, town, or county) (State)<br>Glen Burnie, Md.                                                                                           |  | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                |  |
| 25B. NAME OF REGISTRAR<br>A. J. [Signature]                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | 25C. FUNERAL DIRECTOR<br>McCully                                                                                                                            |  | 25D. ADDRESS<br>237 Patapsco Ave 21225                                                        |  |

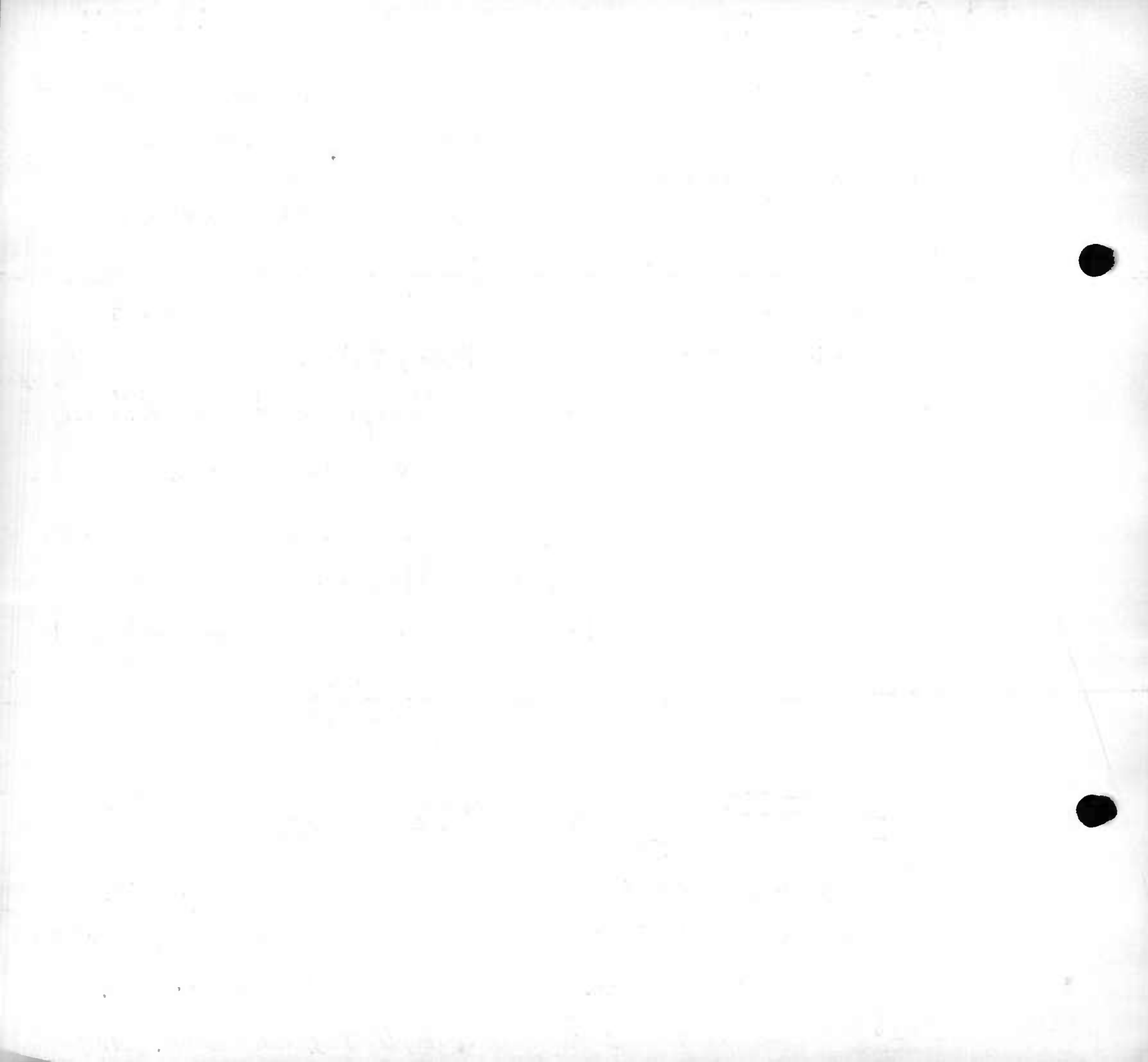




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                    |                         |                                                                                                                                                                                                                                |                                                                                                                    | 72 08734                                                                                                           |                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| P-652                                                                                                                                                                                                                               |                         |                                                                                                                                                                                                                                |                                                                                                                    | 72 08734                                                                                                           |                                                      |
| BIRTH NO.                                                                                                                                                                                                                           |                         |                                                                                                                                                                                                                                |                                                                                                                    | REG. NO.                                                                                                           |                                                      |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Caroline A. Prince</u>                                                                                                                                                                    |                         |                                                                                                                                                                                                                                |                                                                                                                    | 2. DATE AND HOUR OF DEATH<br><u>9-9-72</u> <u>1040</u> P.M.                                                        |                                                      |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                              |                         |                                                                                                                                                                                                                                |                                                                                                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                              |                                                      |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>South Baltimore General Hosp</u><br><u>3001 S. Hanover St.</u>                                                      |                         |                                                                                                                                                                                                                                |                                                                                                                    | A. STATE <u>Md.</u> B. COUNTY <u>Anne Arundel</u>                                                                  |                                                      |
|                                                                                                                                                                                                                                     |                         |                                                                                                                                                                                                                                |                                                                                                                    | C. CITY OR TOWN <u>Glen Burnie</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                      |
|                                                                                                                                                                                                                                     |                         |                                                                                                                                                                                                                                |                                                                                                                    | E. STREET AND NUMBER <u>Box 391 Marley Ave.</u>                                                                    |                                                      |
| 5. SEX<br><u>F.</u>                                                                                                                                                                                                                 | 6. RACE<br><u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                    | 8. DATE OF BIRTH<br><u>6-30-94</u>                                                                                 |                                                                                                                    | 9. AGE (In years last birthday) <u>78</u>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                     |                         |                                                                                                                                                                                                                                | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                  |                                                                                                                    | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                                                                                                                                                             |                         |                                                                                                                                                                                                                                | 13. FATHER'S NAME <u>Joseph Pieffer</u>                                                                            |                                                                                                                    |                                                      |
| 14. MOTHER'S MAIDEN NAME <u>Mary Sykes</u>                                                                                                                                                                                          |                         |                                                                                                                                                                                                                                | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> |                                                                                                                    |                                                      |
| 16. SOCIAL SECURITY NO. <u>220-07-5123</u>                                                                                                                                                                                          |                         |                                                                                                                                                                                                                                | 17. INFORMANT <u>Joseph H. Prince</u> ADDRESS <u>296 Beach Ave.</u>                                                |                                                                                                                    |                                                      |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br><u>43301</u> |                         |                                                                                                                                                                                                                                |                                                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                       |                                                      |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebrovascular Thrombosis</u>                                                                                                                                               |                         |                                                                                                                                                                                                                                |                                                                                                                    | <u>3 weeks</u>                                                                                                     |                                                      |
| (B) Hypertensive Cerebrovascular Disease Sev. Xrs. DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                  |                         |                                                                                                                                                                                                                                |                                                                                                                    |                                                                                                                    |                                                      |
| (C) Systemic Hypertension                                                                                                                                                                                                           |                         |                                                                                                                                                                                                                                |                                                                                                                    | <u>Sev. Years</u>                                                                                                  |                                                      |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Left Lower Lobe Pneumonia</u>                                                          |                         |                                                                                                                                                                                                                                |                                                                                                                    | <u>2 1/2 weeks</u>                                                                                                 |                                                      |
| 19A. DATE OF OPERATION                                                                                                                                                                                                              |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                               |                                                                                                                    | 20A. AUTOPSY? (Yes or No)                                                                                          |                                                      |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                               |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                       |                                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                           |                                                      |
| 21D. TIME OF INJURY (Approx.)                                                                                                                                                                                                       |                         | 21E. INJURY OCCURRED                                                                                                                                                                                                           |                                                                                                                    | 21F. HOW DID INJURY OCCUR?                                                                                         |                                                      |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/20</u> 19 <u>72</u> to <u>9/9</u> 19 <u>72</u>                                                                                                               |                         | that (I) (we) last saw the deceased alive on <u>9/9</u> 19 <u>72</u> and that (in (my)) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. |                                                                                                                    |                                                                                                                    |                                                      |
| 23A. SIGNATURE <u>Byung Chan Rhee</u> DEGREE <u>Phys.</u> Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                 |                         |                                                                                                                                                                                                                                |                                                                                                                    | 23B. DATE SIGNED <u>9/9/72</u>                                                                                     |                                                      |
| 23C. PHYSICIAN'S NAME (Type) <u>Byung Chan Rhee</u> DEGREE                                                                                                                                                                          |                         |                                                                                                                                                                                                                                |                                                                                                                    | 23D. ADDRESS <u>3001 S. Hanover St. Balto. Md. 21230</u>                                                           |                                                      |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                              |                         | 24B. DATE <u>9/14/72</u>                                                                                                                                                                                                       |                                                                                                                    | 24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>                                                              |                                                      |
| 24D. LOCATION (City, town, or county) <u>Wash Blvd Dorsey Md.</u>                                                                                                                                                                   |                         | (State) <u>Md. 21229</u>                                                                                                                                                                                                       |                                                                                                                    | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1972</u>                                                                 |                                                      |
| 25B. NAME OF REGISTRAR <u>Indy...</u>                                                                                                                                                                                               |                         | 25C. FUNERAL DIRECTOR <u>4 Reguly</u>                                                                                                                                                                                          |                                                                                                                    | ADDRESS <u>237 Patapsco Ave. 21225</u>                                                                             |                                                      |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  |                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                      |  | 72 08735                                                                                                                         |  | 72 08735                                                                                   |  |
| P-626                                                                                                                                                                                                                                                                                                 |  | 72 08735                                                                                                                         |  | 72 08735                                                                                   |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                             |  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                           |  | 2. DATE AND HOUR OF DEATH                                                                  |  |
|                                                                                                                                                                                                                                                                                                       |  | PARKER MRS. CARRIE E                                                                                                             |  | 9/9/1972 12 30 A.M.                                                                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)                                             |  | A. STATE B. COUNTY                                                                         |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                  |  | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                               |  | C. CITY OR TOWN D. INSIDE CITY LIMITS?                                                     |  |
| Church Home & Hospital Balto MD.                                                                                                                                                                                                                                                                      |  |                                                                                                                                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |  |
| 5. SEX                                                                                                                                                                                                                                                                                                |  | 6. RACE                                                                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>      |  |
| F                                                                                                                                                                                                                                                                                                     |  | W.                                                                                                                               |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                         |  |
| 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                      |  | 9. AGE (In years last birthday)                                                                                                  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |
| 03-04-1912                                                                                                                                                                                                                                                                                            |  | 60.                                                                                                                              |  | house wife                                                                                 |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                             |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                     |  | 13. FATHER'S NAME                                                                          |  |
| Virginia                                                                                                                                                                                                                                                                                              |  | American.                                                                                                                        |  | JOHN GIBSON.                                                                               |  |
| 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                              |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                         |  | 16. SOCIAL SECURITY NO.                                                                    |  |
| ELLA SHIFFLETT.                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  | 214 22 9164                                                                                |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                         |  | 18. CAUSE OF DEATH                                                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                               |  |
| Charles Parker 3316 McShane Way                                                                                                                                                                                                                                                                       |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                   |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | (A) IMMEDIATE CAUSE                                                                                                              |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | DUE TO, OR AS A CONSEQUENCE OF:                                                                                                  |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | Respiratory Arrest                                                                                                               |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | followed by Cardiac Arrest                                                                                                       |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | due to Myocardial                                                                                                                |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | Infarction.                                                                                                                      |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | (C)                                                                                                                              |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | II                                                                                                                               |  |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                       |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |                                                                                            |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20A. AUTOPSY? (Yes or No)                                                                  |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                         |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                         |  | 21E. INJURY OCCURRED                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                                 |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                           |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                |  |                                                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8/1972 to 9/9/1972 that (I) (we) last saw the deceased alive on 9/8/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                  |  |                                                                                            |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                        |  | 23B. DATE SIGNED                                                                                                                 |  | 23C. PHYSICIAN'S NAME (Type)                                                               |  |
| M. YOUSUF SIDDIQUI MD                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | M. YOUSUF SIDDIQUI MD                                                                      |  |
| 23D. ADDRESS                                                                                                                                                                                                                                                                                          |  | 23E. FUNERAL DIRECTOR                                                                                                            |  | 23F. ADDRESS                                                                               |  |
| Church Home & Hosp. 100 N. Broadway, Balto MD 21231.                                                                                                                                                                                                                                                  |  | WALTER DABROWSKI                                                                                                                 |  | 1005 DUNDALK AVENUE                                                                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                              |  | 24B. DATE                                                                                                                        |  | 24C. NAME OF CEMETERY OR CREMATORY                                                         |  |
| Burial                                                                                                                                                                                                                                                                                                |  | 9-12-72                                                                                                                          |  | Prize Hill Cemetery                                                                        |  |
| 24D. LOCATION                                                                                                                                                                                                                                                                                         |  | 24E. NAME OF REGISTRAR                                                                                                           |  | 24F. FUNERAL DIRECTOR                                                                      |  |
| Boonesville Va                                                                                                                                                                                                                                                                                        |  | Sidney H. H. H.                                                                                                                  |  | WALTER DABROWSKI                                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR                                                                                                           |  | 25C. FUNERAL DIRECTOR                                                                      |  |
| SEP 13 1972                                                                                                                                                                                                                                                                                           |  | Sidney H. H. H.                                                                                                                  |  | WALTER DABROWSKI                                                                           |  |

1941-1942

110.

Green House & Hospital

State of Kansas

03-04-1917

x

F W

Amesbury

Vespera

ELLA SHIFFETT

JOHN GIBSON.

Restoring Green  
House by E. A. Gibson  
for E. Gibson  
Amesbury.

01/21 17  
01/21 17  
01/21 17

W. J. Gibson

W. J. Gibson & Son  
Amesbury, Mass.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO. 72 08736                                                                                                                 |  |
| BIRTH NO. 4-200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 72 08736                                                                                                                          |  |
| 1. NAME OF DECEASED<br>(Type or Print) PAULINE HESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 2. DATE AND HOUR OF DEATH<br>September 9 1972                                                                                     |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY BALTIMORE |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31 920 S. CLINTON STREET<br>BALTIMORE CITY HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | C. CITY OR TOWN<br>BALTIMORE                                                                                                      |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. RACE<br>W                                                                                                                      |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 8. DATE OF BIRTH<br>3-20-1908                                                                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSE WIFE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 9. AGE (In years last birthday)<br>64                                                                                             |  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br>HOME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. BIRTHPLACE (State or foreign country)<br>BALTIMORE                                                                            |  |
| 13. FATHER'S NAME<br>KAROL KAIZER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                      |  |
| 14. MOTHER'S MAIDEN NAME<br>/?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>no                 |  |
| 16. SOCIAL SECURITY NO.<br>213 05 1426                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 17. INFORMANT<br>Rita Smalek 1008 S. CLINTON STREET                                                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>Coronary Thrombosis<br>Hypertensive C.V. Disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | 19. DATE OF OPERATION<br>0                                                                                                        |  |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                              |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                          |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                         |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21F. HOW DID INJURY OCCUR?                                                                                                        |  |
| 22. I certify that (I) (this hospital) attended the deceased from 6/8 1970 to 11/24 1971, that (I) (we) last saw the deceased alive on 11/24 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                           |  | 23A. SIGNATURE<br>J. H. Goodman                                                                                                   |  |
| 23B. DATE SIGNED<br>9/11/72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 23C. PHYSICIAN'S NAME (Type)<br>J. H. Goodman                                                                                     |  |
| 23D. ADDRESS<br>9 S. Highland Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                |  |
| 24B. DATE<br>9-12-72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATORY<br>SACRED HEART OF JESUS                                                                       |  |
| 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE, MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                    |  |
| 25B. NAME OF REGISTRAR<br>Walter Dabrowski                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 25C. FUNERAL DIRECTOR<br>WALTER DABROWSKI 1005 DUNDALK                                                                            |  |
| 25D. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | VS 150 REV. 7/7/68                                                                                                                |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                          |                                                                                                                                                                                                                                                                                                                                            |                                   | 72 08737                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          |                                                                                                                                                                                                                                                                                                                                            |                                   | REG. NO. 72 08737                                                                        |
| BIRTH NO. <u>H-512</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          | STATE OF MARYLAND-DEHM                                                                                                                                                                                                                                                                                                                     |                                   |                                                                                          |
| 1. NAME OF DECEASED<br>(Type or Print) <b>HAMPSON, JOSEPH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          | 2. DATE AND HOUR OF DEATH<br><b>SEPTEMBER 8, 1972 7:40 P.M.</b>                                                                                                                                                                                                                                                                            |                                   |                                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40 ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>BALTO</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>5305 OLD FREDERICK ROAD 21229</b> |                                   |                                                                                          |
| 5. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. RACE <b>CAUCASIAN</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                   | 8. DATE OF BIRTH <b>3/26/1888</b> | 9. AGE (In years last birthday) <b>84</b>                                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                          | 10B. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>                                                                                                                                                                                                                                                                                     |                                   | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                                |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          | 13. FATHER'S NAME <b>CLARENCE HAMPSON</b>                                                                                                                                                                                                                                                                                                  |                                   |                                                                                          |
| 14. MOTHER'S MAIDEN NAME <b>ISABELLA DEMAREST</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                          | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WORLD WAR 1</b>                                                                                                                                                                                                     |                                   |                                                                                          |
| 16. SOCIAL SECURITY NO. <b>1218 14 8817</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                          | 17. INFORMANT <b>BALTIMORE MARYLAND</b> ADDRESS <b>21229 ST AGNES HOSPITAL CATON &amp; WILKENS AVE</b>                                                                                                                                                                                                                                     |                                   |                                                                                          |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Respiratory failure</b><br><b>pneumonia - Septicemia</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                          |                                                                                                                                                                                                                                                                                                                                            |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                           |                                   | 20A. AUTOPSY? (Yes or No) <b>NO</b>                                                      |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                          | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                      |                                   |                                                                                          |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                   |                                   |                                                                                          |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                     |                                   | 21F. HOW DID INJURY OCCUR?                                                               |
| 22. I certify that (X) (this hospital) attended the deceased from <b>SEPTEMBER 8, 1972</b> to <b>SEPTEMBER 8, 1972</b> , that (X) (we) last saw the deceased alive on <b>SEPTEMBER 8, 1972</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXXX) view the body after death.                                                                                                                                                                                                                 |                          |                                                                                                                                                                                                                                                                                                                                            |                                   |                                                                                          |
| 23A. SIGNATURE <b>Yen Huang, M.D.</b> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                                                                                                                                                                                                                                                                                                            |                                   | 23B. DATE SIGNED <b>9/8/72</b>                                                           |
| 23C. PHYSICIAN'S NAME (Type) <b>YEN HUANG, M.D.</b> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                          |                                                                                                                                                                                                                                                                                                                                            |                                   | 23D. ADDRESS <b>WILKENS AVE BALTIMORE MARYLAND ST AGNES HOSPITAL RECORDS-CATON &amp;</b> |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          | 24B. DATE <b>9/12/72</b>                                                                                                                                                                                                                                                                                                                   |                                   | 24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cem.</b>                           |
| 24D. LOCATION (City, town, or county) <b>Catonsville, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          | 24E. STATE (State) <b>Md.</b>                                                                                                                                                                                                                                                                                                              |                                   |                                                                                          |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                          | 25B. NAME OF REGISTRAR <b>Edw. S. MacNabb Sons, Inc.</b>                                                                                                                                                                                                                                                                                   |                                   | 25C. ADDRESS <b>301 Frederick Ave. Catonsville, Md.</b>                                  |

J471920H-23M04 75

2001年5月20日

WALY SAM

DATE RECEIVED: 2/20/17

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XXXXX

• M. 2004. 1034



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                   |                                    |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      | REG. NO. 72 08738                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <b>W-656</b><br><b>72 08738</b><br><b>CERTIFICATE OF DEATH</b><br><b>STATE OF MARYLAND-DEMD</b>                                                                                                                                                                                                                                                                                                                                                    |                                    | <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>WARNER, MAUD BELLE</b>                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                      | <b>2. DATE AND HOUR OF DEATH</b><br><b>SEPTEMBER 9, 1972 9:25 P. M.</b>                                |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>40 ST AGNES HOSPITAL</b>                                                                                                                                                                                                                               |                                    | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>CARROLL</b><br><b>5600</b><br><b>C. CITY OR TOWN</b> <b>SYKESVILLE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br><b>E. STREET AND NUMBER</b> <b>OKLAHOMA ROAD</b> |                                                                                                                                                                                                                                                                      |                                                                                                        |
| <b>5. SEX</b><br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>6. RACE</b><br><b>CAUCASIAN</b> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                                            | <b>8. DATE OF BIRTH</b> <b>03/08/80</b> <b>9. AGE</b> (In years lost birthday) <b>91</b><br><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b> |                                                                                                        |
| <b>11. BIRTHPLACE</b> (State or foreign country) <b>PENNSYLVANIA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                             |                                    | <b>13. FATHER'S NAME</b> <b>JOHN JONES</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>BARBARA (Gettle)</b>                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                      |                                                                                                        |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                       |                                    | <b>16. SOCIAL SECURITY NO.</b> <b>215 05 1986</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                      | <b>17. INFORMANT ADDRESS</b><br><b>ST AGNES HOSPITAL RECORDS CATON AND WILKENS AVES BALTO MD 21229</b> |
| <b>II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                    |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      |                                                                                                        |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>(A) IMMEDIATE CAUSE</b> <b>CVA (C. MIDDLE CEREBRAL OCCLUSION) 2 WKS</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) ASCVD</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C)</b>             |                                    |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      |                                                                                                        |
| <b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>CHF</b>                                                                                                                                                                                                                                                                                             |                                    |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      |                                                                                                        |
| <b>19A. DATE OF OPERATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                      | <b>20A. AUTOPSY? (Yes or No)</b> <b>No</b>                                                             |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                       |                                    | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                        |
| <b>21D. TIME OF INJURY (APPROX.)</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                    | <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                      | <b>21F. HOW DID INJURY OCCUR?</b>                                                                      |
| <b>22. I certify that</b> <b>XX</b> (this hospital) <b>attended the deceased from</b> <b>08/28</b> <b>19 72</b> <b>to</b> <b>09/09</b> <b>19 72</b> , <b>that</b> <b>XX</b> (we) <b>last saw the deceased alive on</b> <b>09/09</b> <b>19 72</b> <b>and that in</b> <b>XX</b> (our) <b>apinian death occurred on the date</b> <b>and hour and from the causes stated above.</b> <b>XX</b> (We) (did) <b>XXXX</b> <b>view the body after death.</b> |                                    |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      |                                                                                                        |
| <b>23A. SIGNATURE</b><br><b>Robert W. Ashmore</b> <b>MD</b> <b>DEGREE</b>                                                                                                                                                                                                                                                                                                                                                                          |                                    |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      | <b>23B. DATE SIGNED</b><br><b>9/9/72</b>                                                               |
| <b>23C. PHYSICIAN'S NAME (Type)</b> <b>ROBERT W ASHMORE, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                    |                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      | <b>23D. ADDRESS</b> <b>ST AGNES HOSPITAL</b>                                                           |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                    | <b>24B. DATE</b> <b>9-13-72</b>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      | <b>24C. NAME of CEMETERY or CREMATORY</b> <b>New OAKland Cemetery</b>                                  |
| <b>24D. LOCATION</b> (City, town, or county) <b>Sykesville</b> (State) <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                  |                                    | <b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 13 1972</b> <b>25B. NAME OF REGISTRAR</b> <b>Sidney H. Hought</b> <b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>Harry W. Hought Sykesville, Md.</b>                                                                                                                                                                        |                                                                                                                                                                                                                                                                      |                                                                                                        |

SEPTEMBER 2, 1972 0:55 P.

UNITED STATES

MARYLAND CARROLL

KEYSVILLE

ST AGNES HOSPITAL

OKLAHOMA

03/08/84 11 32

FEMALE CAUCASIAN X

U.S.A.

PENNSYLVANIA

Home

HOUSEWIFE

04R08A (6-6-1)

JOHN JONES

ST AGNES HOSPITAL RECORDS SECTION  
215 02 1986 WILKINS AVE BALTO MD 21201

NO

00109 37

37

08/18 37

00109 37

37

37

XXXXX

ST AGNES HOSPITAL

FOREST W ASHMORE, M.D.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                            |  |                                                                                          |  | 72 08739                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|
| M-620 72 08739 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |                                                                                          |  | REG. NO. 72 08739                                                                     |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                      |  | 2. DATE AND HOUR OF DEATH                                                                |  |                                                                                       |
| MAYERS GEORGE F                                                                                                                                                                                                                                                                                             |  | 09/10/72 1:15PM M.                                                                       |  |                                                                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                      |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |  |                                                                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                   |  | A. STATE B. COUNTY                                                                       |  |                                                                                       |
| 40 ST AGNES HOSPITAL                                                                                                                                                                                                                                                                                        |  | MARYLAND BALTO 5300                                                                      |  |                                                                                       |
| 5. SEX                                                                                                                                                                                                                                                                                                      |  | 6. RACE                                                                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| MALE                                                                                                                                                                                                                                                                                                        |  | CAUCASIAN                                                                                |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                 |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 9. AGE (In years last birthday)                                                       |
| Construction Worker                                                                                                                                                                                                                                                                                         |  |                                                                                          |  | 64                                                                                    |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY?                                                             |  |                                                                                       |
| MARYLAND                                                                                                                                                                                                                                                                                                    |  | U S A                                                                                    |  |                                                                                       |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME                                                                 |  |                                                                                       |
| GEORGE F MAYERS Sr                                                                                                                                                                                                                                                                                          |  | ALVERTA UHLER                                                                            |  |                                                                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO.                                                                  |  | 17. INFORMANT ADDRESS                                                                 |
| YES WW 2                                                                                                                                                                                                                                                                                                    |  | 214 18 7505                                                                              |  | BALTO MD 21229                                                                        |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                             |  |                                                                                       |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                              |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  |                                                                                       |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                |  | Acute myocardial infarction                                                              |  |                                                                                       |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                           |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  |                                                                                       |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                   |  | Liver embolus & Bleeding                                                                 |  |                                                                                       |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                         |  | from esophageal varices                                                                  |  |                                                                                       |
| II                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  |                                                                                       |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                            |  |                                                                                          |  |                                                                                       |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                             |
| 0                                                                                                                                                                                                                                                                                                           |  |                                                                                          |  | NO                                                                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                               |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                            |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                 |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                       |
| 22. I certify that (X) (this hospital) attended the deceased from 09/09/72 19 to 09/10/72 19, that (X) (we) last saw the deceased alive on 09/10/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. |  |                                                                                          |  |                                                                                       |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                              |  |                                                                                          |  | 23B. DATE SIGNED                                                                      |
| THITIVARANA, THIEN, M.D.                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | 09 10 72                                                                              |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                |  |                                                                                          |  | 23D. ADDRESS                                                                          |
| THIEN THITIVARANA M.D.                                                                                                                                                                                                                                                                                      |  |                                                                                          |  | ST. AGNES HOSPITAL                                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                    |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY                                                    |
| Burial                                                                                                                                                                                                                                                                                                      |  | 9/13/72                                                                                  |  | Loudon Park                                                                           |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                               |  | 25A. DATE REC'D BY HEALTH DEPT.                                                          |  |                                                                                       |
| Baltimore, Maryland                                                                                                                                                                                                                                                                                         |  | SEP 13 1972                                                                              |  |                                                                                       |
| 25B. NAME OF REGISTRAR                                                                                                                                                                                                                                                                                      |  | 25C. FUNERAL DIRECTOR ADDRESS                                                            |  |                                                                                       |
| Leonard J Ruck Inc. Baltimore, Md                                                                                                                                                                                                                                                                           |  |                                                                                          |  |                                                                                       |

ST. AGNES HOSPITAL, NEW YORK  
RECEIVED  
JAN 10 1955

ST. AGNES HOSPITAL, NEW YORK  
RECEIVED  
JAN 10 1955

ST. AGNES HOSPITAL, NEW YORK  
RECEIVED  
JAN 10 1955

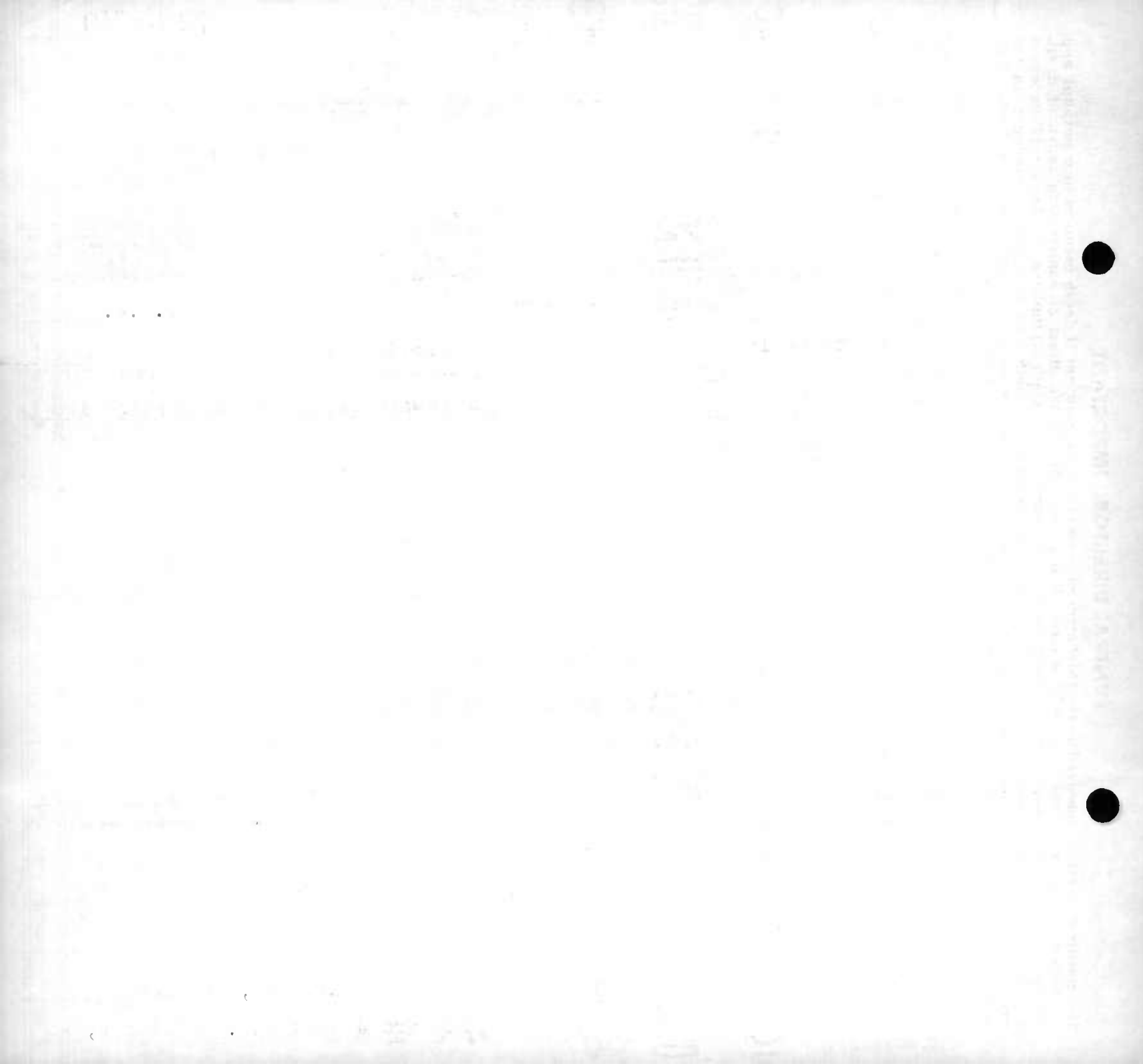
ST. AGNES HOSPITAL, NEW YORK  
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JAN 10 1955

ST. AGNES HOSPITAL, NEW YORK  
RECEIVED  
JAN 10 1955

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>72 08740<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                    | REG. NO. 72 08740                                                                             |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. <u>L-150</u>                                                                                                                                                                                                                                                                                                    |                         | STATE OF MARYLAND - DEATH                                                                                                                                   |                                    |                                                                                               |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Edward Lapin Sr.</u>                                                                                                                                                                                                                                                            |                         | 2. DATE AND HOUR OF DEATH<br><u>September 10, 1972</u> <u>8 00</u> A.M.                                                                                     |                                    |                                                                                               |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                    |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>2743</u>                     |                                    |                                                                                               |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>48 Maryland General Hospital</u>                                                                                                                                                                                                                                               |                         | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                         |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                      |                         | E. STREET AND NUMBER<br><u>3306 Southern Avenue</u>                                                                                                         |                                    |                                                                                               |                                                           |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                     | 6. RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/21/84</u> | 9. AGE (in years last birthday)<br><u>88</u>                                                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>                                                                                                                                                                                                             |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>American Brewery</u>                                                                                                |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Russia</u>                                    |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                             |                         | 13. FATHER'S NAME<br><u>August Lapin</u>                                                                                                                    |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Caroline Eader</u>                                             |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                     |                         | 16. SOCIAL SECURITY NO.<br><u>212-05-9286</u>                                                                                                               |                                    | 17. INFORMANT<br><u>Mr Edward Lapin Jr</u>                                                    |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><u>Aspiration</u>                                                                                                     |                         | CAUSE OF DEATH                                                                                                                                              |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u>                                |                                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>G.I. Bleeding</u>                                                                                                                                                                    |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                                    |                                                                                               |                                                           |
| (C) _____                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                    |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 19A. DATE OF OPERATION<br><u>9/10</u>                                                                                                                                                                                                                                                                                     |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                        |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                     |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                 |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                    | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| 22. I certify that (1) (this hospital) attended the deceased from <u>9/2</u> 19 <u>72</u> to <u>9/10</u> 19 <u>72</u> that (1) last saw the deceased alive on <u>9/9</u> 19 <u>72</u> and that (in my) opinion death occurred on the date and hour and from the causes stated above. (1) (did) view the body after death. |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 23A. SIGNATURE<br><u>Dr. E. Lapin MD</u>                                                                                                                                                                                                                                                                                  |                         | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |                                    | 23B. DATE SIGNED<br><u>9/10/72</u>                                                            |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Dr. Brager/Serpick MD</u>                                                                                                                                                                                                                                                              |                         | 23D. ADDRESS                                                                                                                                                |                                    |                                                                                               |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                 |                         | 24B. DATE<br><u>9/13/72</u>                                                                                                                                 |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Oaklawn</u>                                          |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><u>SEP 13 1972</u>                                                                                                                                                                                                                                                                  |                         | 25B. NAME OF FUNERAL HOME<br><u>Leonard &amp; Ruck Inc.</u>                                                                                                 |                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><u>Baltimore, Md</u>                                         |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>T-416</span> <span>72 08741</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REC. NO. 12 08741</span> <span>STATE OF MARYLAND-DHMH</span> </div>                                                                                                    |                  |                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                           |
| BIRTH NO. _____<br>1. NAME OF DECEASED (Type or Print) <b>DANIEL E. TALBERT</b>                                                                                                                                                                                                                                                                                                                                                                                |                  | 2. DATE AND HOUR OF DEATH<br><b>9/9/72 4:45 PM</b>                                                                                                                                                                                                                                                             |                                                                                                                                                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>LUTHERAN HOSPITAL OF MD.<br/>730, ASHBURTON ST.<br/>BALTO. MD. 21216</b>                                                                                                                                                                                                         |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE _____ B. COUNTY _____<br>C. CITY OR TOWN <b>BALTO, MD 21216</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2634 Harlem Ave</b> |                                                                                                                                                                                           |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE <b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                    | 8. DATE OF BIRTH <b>2-10-95</b><br>9. AGE (In years lost birthday) <b>77</b><br>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b> |
| 11. BIRTHPLACE (State or foreign country) <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 12. CITIZEN OF WHAT COUNTRY? _____                                                                                                                                                                                                                                                                             |                                                                                                                                                                                           |
| 13. FATHER'S NAME <b>?????</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 14. MOTHER'S MAIDEN NAME <b>???</b>                                                                                                                                                                                                                                                                            |                                                                                                                                                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____                                                                                                                                                                                                                                                                                                                                                 |                  | 16. SOCIAL SECURITY NO. <b>215-09-1525</b>                                                                                                                                                                                                                                                                     |                                                                                                                                                                                           |
| 17. INFORMANT <b>Mr Robert Hines, 219 N Dennison St</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                  | ADDRESS _____                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                           |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute cardiorespiratory arrest</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,<br><b>Ch Lung, upper GI Bleeding &amp; terminal Aspiration</b> |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____                                                                                                                                                                                                                                                             |                                                                                                                                                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                           |
| 19A. DATE OF OPERATION _____                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____                                                                                                                                                                                                                                                         |                                                                                                                                                                                           |
| 20A. AUTOPSY? (Yes or No) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____                                                                                                                                                                                                                                     |                                                                                                                                                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                 |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____                                                                                                                                                                                                                 |                                                                                                                                                                                           |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____                                                                                                                                                                                                                                                                                                                                                                                 |                  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____                                                                                                                                                                                                                                                |                                                                                                                                                                                           |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                              |                  | 21F. HOW DID INJURY OCCUR? _____                                                                                                                                                                                                                                                                               |                                                                                                                                                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                              |                  |                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                           |
| 23A. SIGNATURE <b>S. S. Dongre</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 23B. DATE SIGNED _____                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                           |
| 23C. PHYSICIAN'S NAME (Type) <b>DR. S. S. DONGRE</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 23D. ADDRESS <b>730, ASHBURTON ST. BALTO. MD. 21216</b>                                                                                                                                                                                                                                                        |                                                                                                                                                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 24B. DATE <b>9/15/72</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                           |
| 24C. NAME OF CEMETERY OR CREMATORY <b>MT Auburn Cemetry</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, M</b>                                                                                                                                                                                                                                              |                                                                                                                                                                                           |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>                                                                                                                                                                                                                                                                |                                                                                                                                                                                           |
| 25C. FUNERAL DIRECTOR <b>1473000 4737</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | ADDRESS <b>1206 W North Ave</b>                                                                                                                                                                                                                                                                                |                                                                                                                                                                                           |





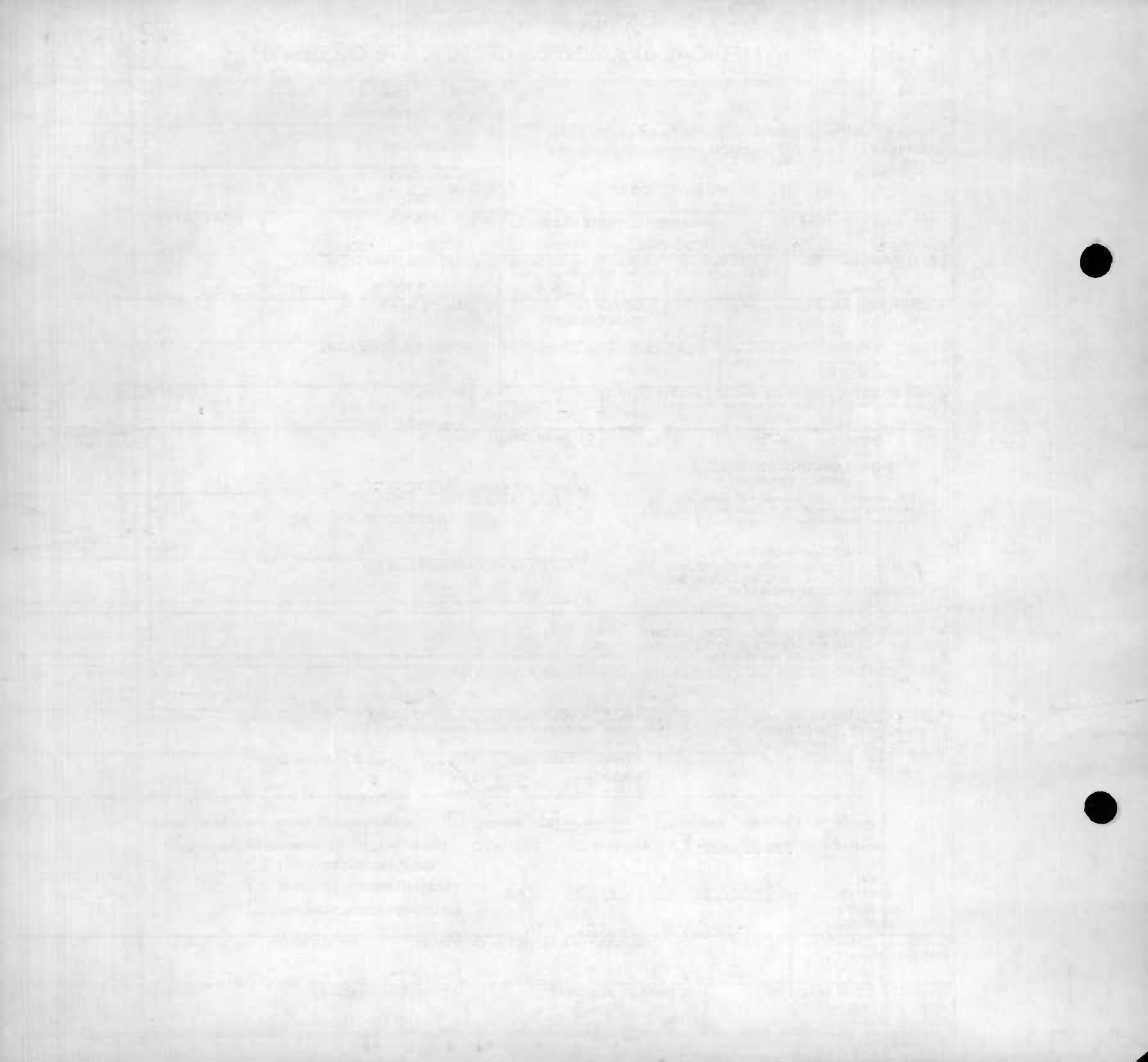


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                  |                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br>L. V. Pugh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month 9 Day 6 Year 72<br>Hour 11:45 P.M.     |                                                                                               |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1318 W. Lanvale Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 6 Year 72<br>Hour 11:45 P.M.                                                                              |                                                                                               |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1602                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                  |                                                                                               |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 7. RACE<br>Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN<br>Baltimore                                                                  |
| 9. DATE OF BIRTH<br>1910                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 10. AGE (in years last birthday)<br>62                                                                                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)<br>??                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 12. CITIZEN OF<br>WHAT COUNTRY?<br>??                                                                                                            | E. STREET AND NUMBER<br>1318 W. Lanvale Street                                                |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 15. MOTHER'S MAIDEN NAME<br>??                                                                                                                   |                                                                                               |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 17. SOCIAL SECURITY NO.<br>425-22-2142                                                                                                           | 18. INFORMANT<br>Mrs Shirley Mae Wells, 1617 Halkesley Place                                  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                      |                  |                                                                                                                                                  |                                                                                               |
| 20A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                                                               |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |                                                                                               |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                        |                                                                                               |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 21. AUTOPSY? (Yes or No)<br>No                                                                                                                   |                                                                                               |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>Marvin S. Platt, M.D.</i> M.D.<br>EXAMINER'S NAME (Type) Marvin S. Platt, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 9-7-72 |                  |                                                                                                                                                  |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 24B. DATE<br>9/12/72                                                                                                                             |                                                                                               |
| 24C. NAME OF CEMETERY or CREMATORY<br>MT Calvary Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 24D. LOCATION (City, town, or county) (State)<br>A A County Md                                                                                   |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 25B. NAME OF REGISTRAR<br><i>Lidney Johnson</i>                                                                                                  |                                                                                               |
| 25C. FUNERAL DIRECTOR<br>Adolphus Halstead 1206 W North Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 25D. ADDRESS                                                                                                                                     |                                                                                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

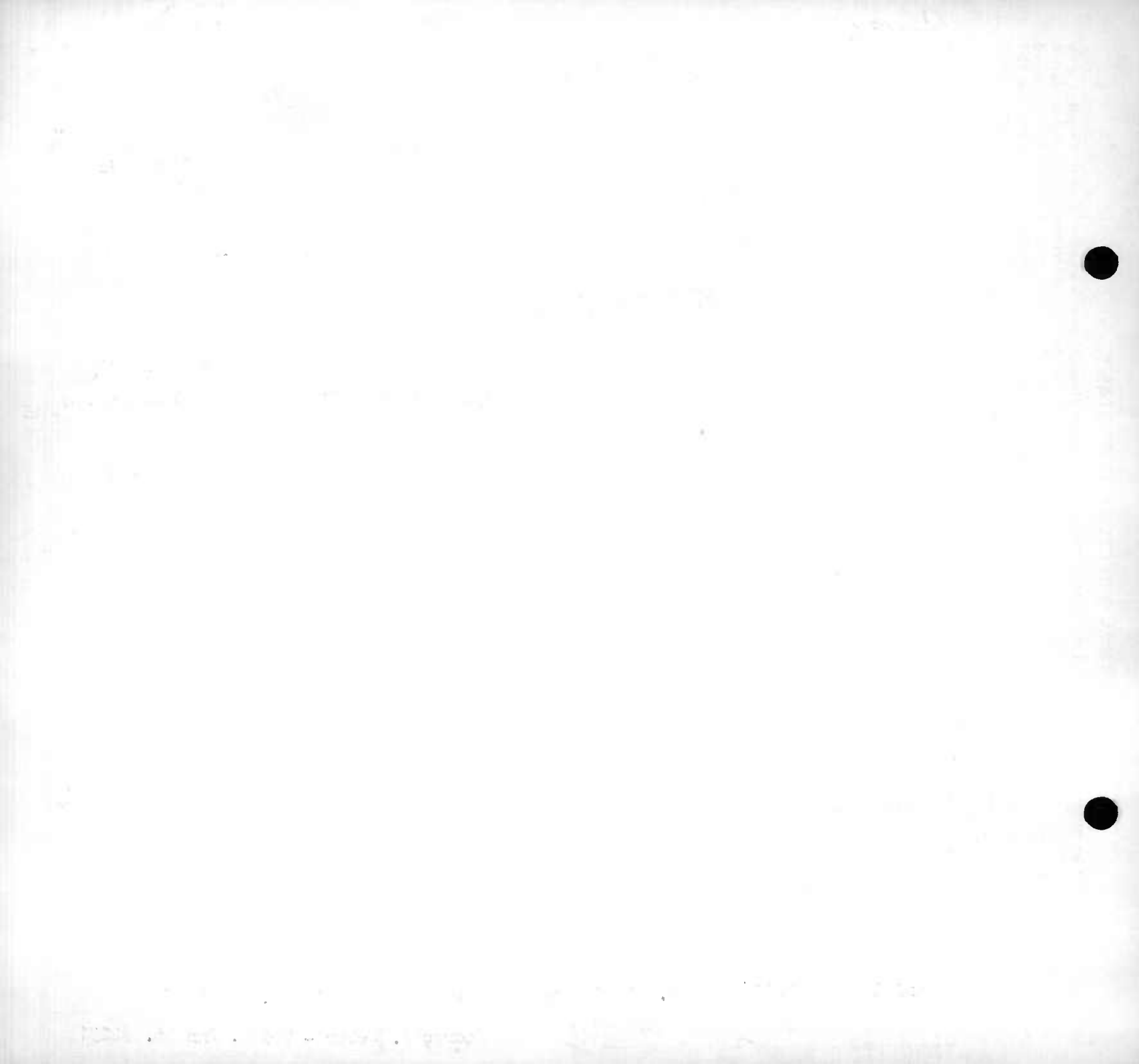
| BIRTH NO.                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT |  | 72 08743                                                                                                                                                                                  |  | REC. NO. 72 08743 |  | STATE OF MARYLAND-DEME                                                        |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------|--|-------------------------------------------------------------------------------|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                       |  |                                  |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                                 |  |                   |  |                                                                               |  |  |  |
| Marjorie Delaney                                                                                                                             |  |                                  |  | 9/8/72                                                                                                                                                                                    |  |                   |  |                                                                               |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                       |  |                                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)                                                                                                     |  |                   |  |                                                                               |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                    |  |                                  |  | A. STATE                                                                                                                                                                                  |  |                   |  | B. COUNTY                                                                     |  |  |  |
| 1128 W Lafayette Ave                                                                                                                         |  |                                  |  | Md                                                                                                                                                                                        |  |                   |  | 1601                                                                          |  |  |  |
| 5. SEX                                                                                                                                       |  |                                  |  | 6. RACE                                                                                                                                                                                   |  |                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    |  |  |  |
| F                                                                                                                                            |  |                                  |  | C                                                                                                                                                                                         |  |                   |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 8. DATE OF BIRTH                                                                                                                             |  |                                  |  | 9. AGE (In years last birthday)                                                                                                                                                           |  |                   |  | 10. CITIZEN OF WHAT COUNTRY?                                                  |  |  |  |
| 4/9/10                                                                                                                                       |  |                                  |  | 62                                                                                                                                                                                        |  |                   |  | U S A                                                                         |  |  |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                    |  |                                  |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                              |  |                   |  |                                                                               |  |  |  |
| Baltimore, Md                                                                                                                                |  |                                  |  | U S A                                                                                                                                                                                     |  |                   |  |                                                                               |  |  |  |
| 13. FATHER'S NAME                                                                                                                            |  |                                  |  | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                  |  |                   |  |                                                                               |  |  |  |
| Herbert Wilson                                                                                                                               |  |                                  |  | Julia                                                                                                                                                                                     |  |                   |  |                                                                               |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                     |  |                                  |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                   |  |                   |  | 17. INFORMANT ADDRESS                                                         |  |  |  |
|                                                                                                                                              |  |                                  |  |                                                                                                                                                                                           |  |                   |  | Mrs Lancaster ,                                                               |  |  |  |
| 18. CAUSE OF DEATH                                                                                                                           |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                              |  |                   |  |                                                                               |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                               |  |                                  |  | HAS CVD                                                                                                                                                                                   |  |                   |  | years                                                                         |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  |                                  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                       |  |                   |  |                                                                               |  |  |  |
| ANTECEDENT CAUSES                                                                                                                            |  |                                  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                       |  |                   |  |                                                                               |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |  |                                  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                       |  |                   |  |                                                                               |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).          |  |                                  |  |                                                                                                                                                                                           |  |                   |  |                                                                               |  |  |  |
| 19A. DATE OF OPERATION                                                                                                                       |  |                                  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                          |  |                   |  | 20A. AUTOPSY? (Yes or No)                                                     |  |  |  |
|                                                                                                                                              |  |                                  |  |                                                                                                                                                                                           |  |                   |  | No                                                                            |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                        |  |                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                   |  |                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)      |  |  |  |
|                                                                                                                                              |  |                                  |  |                                                                                                                                                                                           |  |                   |  |                                                                               |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                              |  |                                  |  | 21E. INJURY OCCURRED                                                                                                                                                                      |  |                   |  | 21F. HOW DID INJURY OCCUR?                                                    |  |  |  |
|                                                                                                                                              |  |                                  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                         |  |                   |  |                                                                               |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1-12-1971 to 8-22-1972                                                     |  |                                  |  | that (I) last saw the deceased alive on 8-22-1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. |  |                   |  |                                                                               |  |  |  |
| 23A. SIGNATURE                                                                                                                               |  |                                  |  | 23B. DATE SIGNED                                                                                                                                                                          |  |                   |  |                                                                               |  |  |  |
| Dr. Gonzalez                                                                                                                                 |  |                                  |  | 9-11-72                                                                                                                                                                                   |  |                   |  |                                                                               |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                 |  |                                  |  | 23D. ADDRESS                                                                                                                                                                              |  |                   |  |                                                                               |  |  |  |
| ANGEL S. GONZALEZ                                                                                                                            |  |                                  |  | 301 McMechen St - 21217                                                                                                                                                                   |  |                   |  |                                                                               |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                     |  |                                  |  | 24B. DATE                                                                                                                                                                                 |  |                   |  | 24C. NAME OF CEMETERY OR CREMATORY                                            |  |  |  |
| Burial                                                                                                                                       |  |                                  |  | 9/12/72                                                                                                                                                                                   |  |                   |  | Arbutus Mem Park                                                              |  |  |  |
| 24D. LOCATION (City, town, or county)                                                                                                        |  |                                  |  | 24E. DATE REC'D BY HEALTH DEPT.                                                                                                                                                           |  |                   |  | 24F. NAME OF REGISTRAR                                                        |  |  |  |
| Woodlawn Md                                                                                                                                  |  |                                  |  | SEP 13 1972                                                                                                                                                                               |  |                   |  | Adolphus Halstead                                                             |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                              |  |                                  |  | 25B. NAME OF REGISTRAR                                                                                                                                                                    |  |                   |  | 25C. FUNERAL DIRECTOR ADDRESS                                                 |  |  |  |
|                                                                                                                                              |  |                                  |  |                                                                                                                                                                                           |  |                   |  | 1206 W North Ave                                                              |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| G-432                                                                                                                                                                                                                                                                                                             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                 |  | 72 08744                                                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                         |  | CERTIFICATE OF DEATH                                                                                                             |  |                                                                                            |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                            |  | 2. DATE AND HOUR OF DEATH                                                                                                        |  | REG. NO. 72 08744                                                                          |  |
| AMELIA GOLDYS                                                                                                                                                                                                                                                                                                     |  | 9. 11. 72                                                                                                                        |  | 2:00 P M.                                                                                  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                            |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                            |  |                                                                                            |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)                                                                                                                                                                                                         |  | A. STATE                                                                                                                         |  |                                                                                            |  |
| Church Home & Hospital                                                                                                                                                                                                                                                                                            |  | Md.                                                                                                                              |  |                                                                                            |  |
| 35                                                                                                                                                                                                                                                                                                                |  | C. CITY OR TOWN                                                                                                                  |  | D. INSIDE CITY LIMITS?                                                                     |  |
| CITY                                                                                                                                                                                                                                                                                                              |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                              |  | 103                                                                                        |  |
| E. STREET AND NUMBER                                                                                                                                                                                                                                                                                              |  | 518 S. ROSE ST. 21224                                                                                                            |  |                                                                                            |  |
| 5. SEX                                                                                                                                                                                                                                                                                                            |  | 6. RACE                                                                                                                          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>      |  |
| F                                                                                                                                                                                                                                                                                                                 |  | W                                                                                                                                |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                         |  |
| 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                                  |  | 9. AGE (In years last birthday)                                                                                                  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |
| 12. 31. 06                                                                                                                                                                                                                                                                                                        |  | 65                                                                                                                               |  | MAID IN CHURCH                                                                             |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                     |  | 13. FATHER'S NAME                                                                          |  |
| MARYLAND                                                                                                                                                                                                                                                                                                          |  | U. S. A.                                                                                                                         |  | JOSEPH GOLDYS                                                                              |  |
| 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                          |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                         |  |                                                                                            |  |
| KATHERINE KENDZIOR                                                                                                                                                                                                                                                                                                |  | No No                                                                                                                            |  |                                                                                            |  |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                           |  | 17. INFORMANT ADDRESS                                                                                                            |  |                                                                                            |  |
| 219-40-8016                                                                                                                                                                                                                                                                                                       |  | MRS MARY CIESLINSKI 616 S. MARYFORD AVE                                                                                          |  |                                                                                            |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                     |  |                                                                                            |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                    |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                              |  |                                                                                            |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                        |  | Acute M.I.                                                                                                                       |  |                                                                                            |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                 |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |                                                                                            |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                         |  | Cirrhosis of liver                                                                                                               |  |                                                                                            |  |
| II                                                                                                                                                                                                                                                                                                                |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |                                                                                            |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20A. AUTOPSY? (Yes or No)                                                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                         |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                                 |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                       |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                |  |                                                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9. 10. 19 72 to 9. 11. 19 72 that (I) (we) last saw the deceased alive on 9. 11. 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                  |  |                                                                                            |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                    |  | 23B. DATE SIGNED                                                                                                                 |  | 23C. PHYSICIAN'S NAME (Type)                                                               |  |
| SATPAL SINGH M.D.                                                                                                                                                                                                                                                                                                 |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23D. ADDRESS                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                          |  | 24B. DATE                                                                                                                        |  | 24C. NAME of CEMETERY or CREMATORY                                                         |  |
| Burial                                                                                                                                                                                                                                                                                                            |  | 9/14/72                                                                                                                          |  | St. Stanislaus Cemetery                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR                                                                                                           |  | 25C. FUNERAL DIRECTOR ADDRESS                                                              |  |
| SEP 13 1972                                                                                                                                                                                                                                                                                                       |  | George A. Weber                                                                                                                  |  | 705 S. Ann St. #2231                                                                       |  |

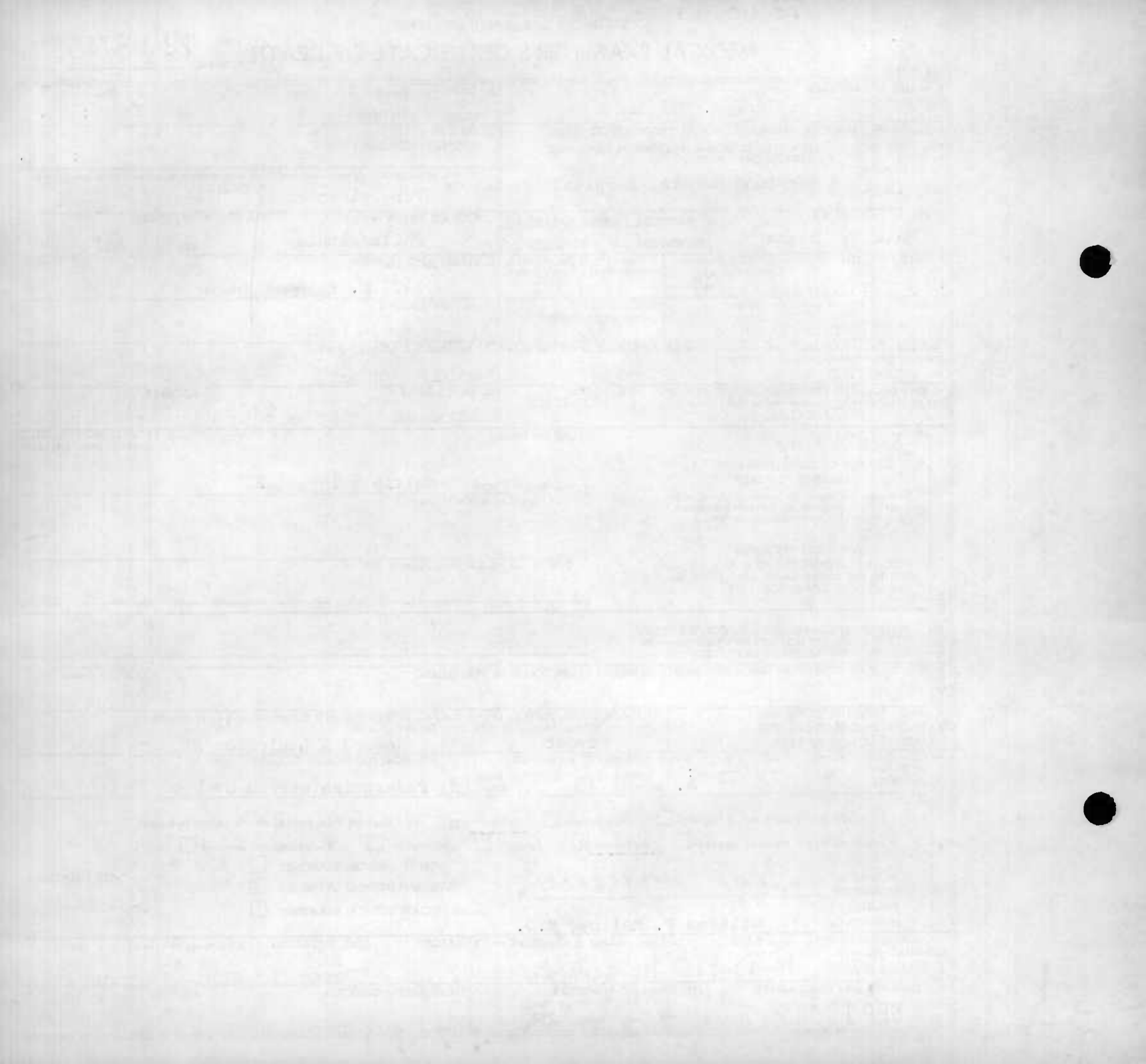


# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) William H. Griffin                                                                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 7 Year 72 Hour 10:50 P. M.                            |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Maryland General Hospital                                                                                                                                                                                                                         |  | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 7 Year 72 Hour 10:50 P. M.                                                                                                  |  |
| 6. SEX Male                                                                                                                                                                                                                                                                                                                                                                                               |  | 7. RACE Negro                                                                                                                                                      |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                  |  | C. CITY OR TOWN Philadelphia                                                                                                                                       |  |
| 9. DATE OF BIRTH May 22nd, 1932                                                                                                                                                                                                                                                                                                                                                                           |  | 10. AGE (In years lost birthday) 40                                                                                                                                |  |
| 11. BIRTHPLACE (State or foreign country) Wayne Pennsylvania                                                                                                                                                                                                                                                                                                                                              |  | 12. CITIZEN OF WHAT COUNTRY? USA                                                                                                                                   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer                                                                                                                                                                                                                                                                                                       |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean                                                                                                                                                                                                                                                                                        |  | 17. SOCIAL SECURITY NO.                                                                                                                                            |  |
| 13. FATHER'S NAME Clarence Griffin                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME Mable Doughty                                                                                                                             |  |
| 18. INFORMANT Clarence Griffin                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS 1425 Redfield St Philadelphia                                                                                                                              |  |
| 19. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                    |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                              |  |                                                                                                                                                                    |  |
| (A) IMMEDIATE CAUSE Multiple injuries<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                    |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                    |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                    |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                    |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                           |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street                                                                    |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 9 7 72 4:18 A. M.                                                                                                                                                                                                                                                                                                                                         |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Howard & Lexington Streets                                                                                                                                                                                                                                                                                                       |  | 22F. HOW DID INJURY OCCUR? Pedestrian struck by bus                                                                                                                |  |
| 21. AUTOPSY? (Yes or No) Yes                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                    |  |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                    |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.                                                                                                                                                                                                                                                                                                                                           |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                           |  | 24B. DATE 9-13-72                                                                                                                                                  |  |
| 24C. NAME OF CEMETERY or CREMATORY Mt Lawn Cemetery                                                                                                                                                                                                                                                                                                                                                       |  | 24D. LOCATION (City, town, or county) (State) Darby Township, Pennsylvania                                                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1972                                                                                                                                                                                                                                                                                                                                                               |  | 25B. NAME OF REGISTRAR Andrew [Signature]                                                                                                                          |  |
| 25C. FUNERAL DIRECTOR Nutter Funeral Home                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS 3035 W. North Av                                                                                                                                           |  |

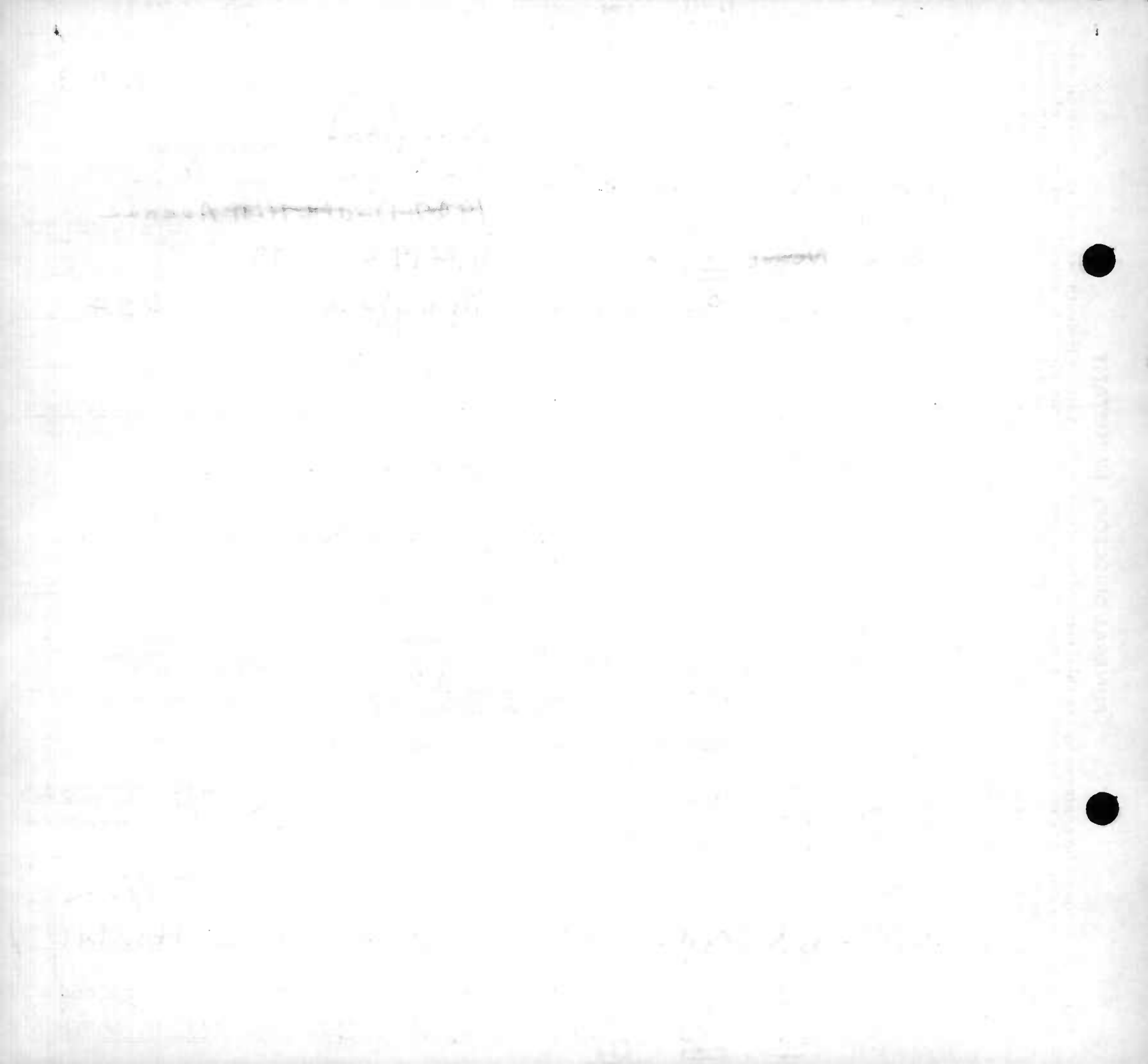




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                              |                                                                                                                                                              |                              |                                                                                               |                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------|
| J-520                                                                                                                                                                                                                                                                                                                                          |                  | 72 08746                                                                                                                                                    |                              | BALTIMORE CITY HEALTH DEPT.                                                                                                                                  |                              | REG. NO. 72 08746                                                                             |                               |
| <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>STATE OF MARYLAND-DEME</span> </div>                                                                                                                                                                               |                  |                                                                                                                                                             |                              |                                                                                                                                                              |                              |                                                                                               |                               |
| 1. NAME OF DECEASED<br>(Type or Print) Effie I. Jones                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             |                              | 2. DATE AND HOUR OF DEATH<br>9/9/72 7:10 P. M.                                                                                                               |                              |                                                                                               |                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                              | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)                                                                        |                              |                                                                                               |                               |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                                           |                  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                              | A. STATE<br>Maryland                                                                                                                                         |                              | B. COUNTY<br>1403                                                                             |                               |
| Maryland General Hospital                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |                              | C. CITY OR TOWN<br>Baltimore                                                                                                                                 |                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |
|                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                              | E. STREET AND NUMBER<br>1927 Druid Hill Avenue                                                                                                               |                              |                                                                                               |                               |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                               | 6. RACE<br>Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>11/22/92 | 9. AGE (In years last birthday)<br>59                                                                                                                        | 10. Under 1 Yr. Months: Days |                                                                                               | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Domestic                                                                                                                                                                                                                                        |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Ret. Family                                                                                                            |                              | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                        |                              | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                           |                               |
| 13. FATHER'S NAME<br>John W. Jones                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             |                              | 14. MOTHER'S MARDEN NAME<br>Gussie Nolan                                                                                                                     |                              |                                                                                               |                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                 |                  | 16. SOCIAL SECURITY NO.<br>219-30-7923                                                                                                                      |                              | 17. INFORMANT<br>Mrs. Kathryn Holliday 3016 Rayner Ave.                                                                                                      |                              |                                                                                               |                               |
| 18. 722.91<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |                                                                                                                                                             |                              | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Cerebral Vascular Accident<br>(B) Systemic Embolism from Atrial Fibrillation<br>(C) |                              |                                                                                               |                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                               |                  |                                                                                                                                                             |                              |                                                                                                                                                              |                              |                                                                                               |                               |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                    |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                              | 20A. AUTOPSY? (Yes or No)<br>NO                                                                                                                              |                              | 20B. (IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?)                        |                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                          |                  | 21B. PLACE OF (INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                   |                              | 21C. WHERE DID (INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |                              |                                                                                               |                               |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                   |                  | 21E. (INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                     |                              | 21F. HOW DID (INJURY OCCUR?                                                                                                                                  |                              |                                                                                               |                               |
| 22. I certify that (I) (this hospital) attended the deceased from 8/25 1972 to 9/9 1972 that (I) (we) last saw the deceased alive on 9/9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                         |                  |                                                                                                                                                             |                              |                                                                                                                                                              |                              |                                                                                               |                               |
| 23A. SIGNATURE<br>William R. Davidson M.D.                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                              | 23B. DATE SIGNED<br>9/9/72                                                                                                                                   |                              | 23C. PHYSICIAN'S NAME (Type)<br>William R. Davidson M.D.                                      |                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                             |                  | 24B. DATE<br>9-14-72                                                                                                                                        |                              | 24C. NAME of CEMETERY or CREMATORY<br>Arbutus Memorial Park                                                                                                  |                              | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Co., Maryland                      |                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                                 |                  | 25B. NAME OF REGISTRAR<br>Sidney [Signature]                                                                                                                |                              | 25C. FUNERAL DIRECTOR<br>NUTTER FUNERAL HOME 3035 W. NORTH AVE                                                                                               |                              |                                                                                               |                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                                                                                                                                                                                                         |                            |                                                                                                                               |                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>4-536</span> <span>72 08717</span> <span>72 08717</span> </div>                                                                                                                                                                                                                     |                  | <div style="display: flex; justify-content: space-between;"> <span>DEPARTMENT</span> <span>CERTIFICATE OF DEATH</span> </div>                                                                                                                                                                                                           |                            | <div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>STATE OF MARYLAND-DEMH</span> </div> |                                                             |
| BIRTH NO. <span style="float: right;">745A-M</span><br>1. NAME OF DECEASED (Type or Print) <span style="float: right;">72</span><br>Lottie E. Henderson                                                                                                                                                                                                |                  | 2. DATE AND HOUR OF DEATH<br>Sept. 9th 1972                                                                                                                                                                                                                                                                                             |                            |                                                                                                                               |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Maryland General Hosp.                                                                                                                                                      |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <span style="float: right;">1702</span><br>MARYLAND<br>C. CITY OR TOWN <span style="float: right;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></span><br>BALTIMORE<br>E. STREET AND NUMBER<br>1003 TIFFANY CT. |                            |                                                                                                                               |                                                             |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br>Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                             | 8. DATE OF BIRTH<br>6/3/98 | 9. AGE (In years lost birthday)<br>74                                                                                         | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                                                               |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                                                                                                                                                                                                                               |                            | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                         |                                                             |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                    |                  | 13. FATHER'S NAME<br>Thomas Barkley                                                                                                                                                                                                                                                                                                     |                            | 14. MOTHER'S MAIDEN NAME<br>Josephine ?                                                                                       |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                         |                  | 16. SOCIAL SECURITY NO.<br>217-14-5376                                                                                                                                                                                                                                                                                                  |                            | 17. INFORMANT ADDRESS<br>Mr. Warren Barkley 4601 Forest Park Ave                                                              |                                                             |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |                                                                                                                                                                                                                                                                                                                                         |                            |                                                                                                                               |                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |                  |                                                                                                                                                                                                                                                                                                                                         |                            |                                                                                                                               |                                                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                        |                            | 20A. AUTOPSY? (Yes or No)                                                                                                     |                                                             |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                            |                            |                                                                                                                               |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                      |                                                             |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                          |                  | 21E. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                    |                            | 21F. HOW DID INJURY OCCUR?                                                                                                    |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                      |                  | 23A. SIGNATURE <span style="float: right;">DEGREE</span><br>H. S. LANGANATH                                                                                                                                                                                                                                                             |                            |                                                                                                                               |                                                             |
| 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                                                       |                  | 23C. PHYSICIAN'S NAME (Type)<br>H. S. LANGANATH                                                                                                                                                                                                                                                                                         |                            |                                                                                                                               |                                                             |
| 23D. ADDRESS<br>Md Gen Hosp. Balto. Md 21201                                                                                                                                                                                                                                                                                                           |                  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                      |                            |                                                                                                                               |                                                             |
| 24B. DATE<br>9-13-72                                                                                                                                                                                                                                                                                                                                   |                  | 24C. NAME of CEMETERY or CREMATORY<br>Baltimore National Cem                                                                                                                                                                                                                                                                            |                            | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Maryland                                                           |                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                                         |                  | 25B. NAME OF REGISTRAR<br>Andrew Johnson                                                                                                                                                                                                                                                                                                |                            | 25C. FUNERAL DIRECTOR ADDRESS<br>NUTTER FUNERAL HOME 3035 W. NORTH AVE                                                        |                                                             |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                     |                                 |                                                                                                                                                                                                                                                                                                                                                  |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| <p>1. NAME OF DECEASED<br/>(Type or Print)<br/><b>Virginia E. Fields</b></p>                                                                                                                                                                                                                                                                                                                                                                 |                                 | <p>2. DATE AND HOUR OF DEATH<br/><b>September 8, 1972   2:45 P.M.</b></p>                                                                                                                                                                                                                                                                        |                                              |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/><b>4006 Gelston Drive</b></p>                                                                                                                                                                                                                                 |                                 | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br/>A. STATE <b>Maryland</b><br/>B. COUNTY <b>1608</b></p> <p>C. CITY OR TOWN <b>Baltimore</b><br/>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>4006 Gelston Drive</b></p> |                                              |
| <p>5. SEX<br/><b>Female</b></p>                                                                                                                                                                                                                                                                                                                                                                                                              | <p>6. RACE<br/><b>Negro</b></p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>                                                                                                                                                                              | <p>8. DATE OF BIRTH<br/><b>5-10-1911</b></p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br/><b>cafeteria worker</b></p>                                                                                                                                                                                                                                                                                                               |                                 | <p>10B. KIND OF BUSINESS OR INDUSTRY<br/><b>Community College of Baltimore</b></p>                                                                                                                                                                                                                                                               |                                              |
| <p>11. BIRTHPLACE (State or foreign country)<br/><b>Virginia</b></p>                                                                                                                                                                                                                                                                                                                                                                         |                                 | <p>12. CITIZEN OF WHAT COUNTRY?<br/><b>USA</b></p>                                                                                                                                                                                                                                                                                               |                                              |
| <p>13. FATHER'S NAME<br/><b>Sam Evans</b></p>                                                                                                                                                                                                                                                                                                                                                                                                |                                 | <p>14. MOTHER'S MAIDEN NAME<br/><b>Lena Ruffin</b></p>                                                                                                                                                                                                                                                                                           |                                              |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br/><b>No</b></p>                                                                                                                                                                                                                                                                                                                |                                 | <p>16. SOCIAL SECURITY NO.<br/><b>219-12-8324</b></p>                                                                                                                                                                                                                                                                                            |                                              |
| <p>17. INFORMANT<br/><b>Mr. Morris Fields 4006 Gelston Dr.</b></p>                                                                                                                                                                                                                                                                                                                                                                           |                                 |                                                                                                                                                                                                                                                                                                                                                  |                                              |
| <p>18. <b>I</b><br/>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br/>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/><b>CAUSE OF DEATH</b><br/><b>The faste Ca of Breast</b><br/>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br/><b>2 yrs</b><br/>(B) DUE TO, OR AS A CONSEQUENCE OF:<br/>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> |                                 |                                                                                                                                                                                                                                                                                                                                                  |                                              |
| <p>19. ANTECEDENT CAUSES<br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br/><b>II</b><br/>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>                                                                                                                                                |                                 |                                                                                                                                                                                                                                                                                                                                                  |                                              |
| <p>19A. DATE OF OPERATION<br/><b>May 70</b></p>                                                                                                                                                                                                                                                                                                                                                                                              |                                 | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br/><b>Ca of Breast</b></p>                                                                                                                                                                                                                                                                  |                                              |
| <p>20A. AUTOPSY? (Yes or No)<br/><b>No</b></p>                                                                                                                                                                                                                                                                                                                                                                                               |                                 | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>                                                                                                                                                                                                                                                                      |                                              |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br/><input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                    |                                 | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                                                                                                                                                                                                  |                                              |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                                                                                                                              |                                 | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br/>(APPROX.)</p>                                                                                                                                                                                                                                                                             |                                              |
| <p>21E. INJURY OCCURRED<br/>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                            |                                 | <p>21F. HOW DID INJURY OCCUR?</p>                                                                                                                                                                                                                                                                                                                |                                              |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>May 70</b> to <b>Sept 1972</b>, that (I) (we) last saw the deceased alive on <b>8 Sept 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>                                                                                                         |                                 |                                                                                                                                                                                                                                                                                                                                                  |                                              |
| <p>23A. SIGNATURE<br/><b>Emerson C. Walden</b></p>                                                                                                                                                                                                                                                                                                                                                                                           |                                 | <p>23B. DATE SIGNED<br/><b>11 Sept 72</b></p>                                                                                                                                                                                                                                                                                                    |                                              |
| <p>23C. PHYSICIAN'S NAME (Type)<br/><b>Emerson C. Walden</b></p>                                                                                                                                                                                                                                                                                                                                                                             |                                 | <p>23D. ADDRESS<br/><b>M. D. 4200 Edmondson Avenue</b></p>                                                                                                                                                                                                                                                                                       |                                              |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)<br/><b>Burial</b></p>                                                                                                                                                                                                                                                                                                                                                                            |                                 | <p>24B. DATE<br/><b>9-13-72</b></p>                                                                                                                                                                                                                                                                                                              |                                              |
| <p>24C. NAME OF CEMETERY or CREMATORY<br/><b>St. Stephen Cemetery</b></p>                                                                                                                                                                                                                                                                                                                                                                    |                                 | <p>24D. LOCATION (City, town, or county) (State)<br/><b>Elkridge Maryland</b></p>                                                                                                                                                                                                                                                                |                                              |
| <p>25A. DATE REC'D BY HEALTH DEPT.<br/><b>SEP 13 1972</b></p>                                                                                                                                                                                                                                                                                                                                                                                |                                 | <p>25B. NAME OF REGISTRAR<br/><b>Adrienne Johnson</b></p>                                                                                                                                                                                                                                                                                        |                                              |
| <p>25C. FUNERAL DIRECTOR<br/><b>NUTTER FUNERAL HOME 3035 W. NORTH AVE</b></p>                                                                                                                                                                                                                                                                                                                                                                |                                 | <p>25D. ADDRESS</p>                                                                                                                                                                                                                                                                                                                              |                                              |

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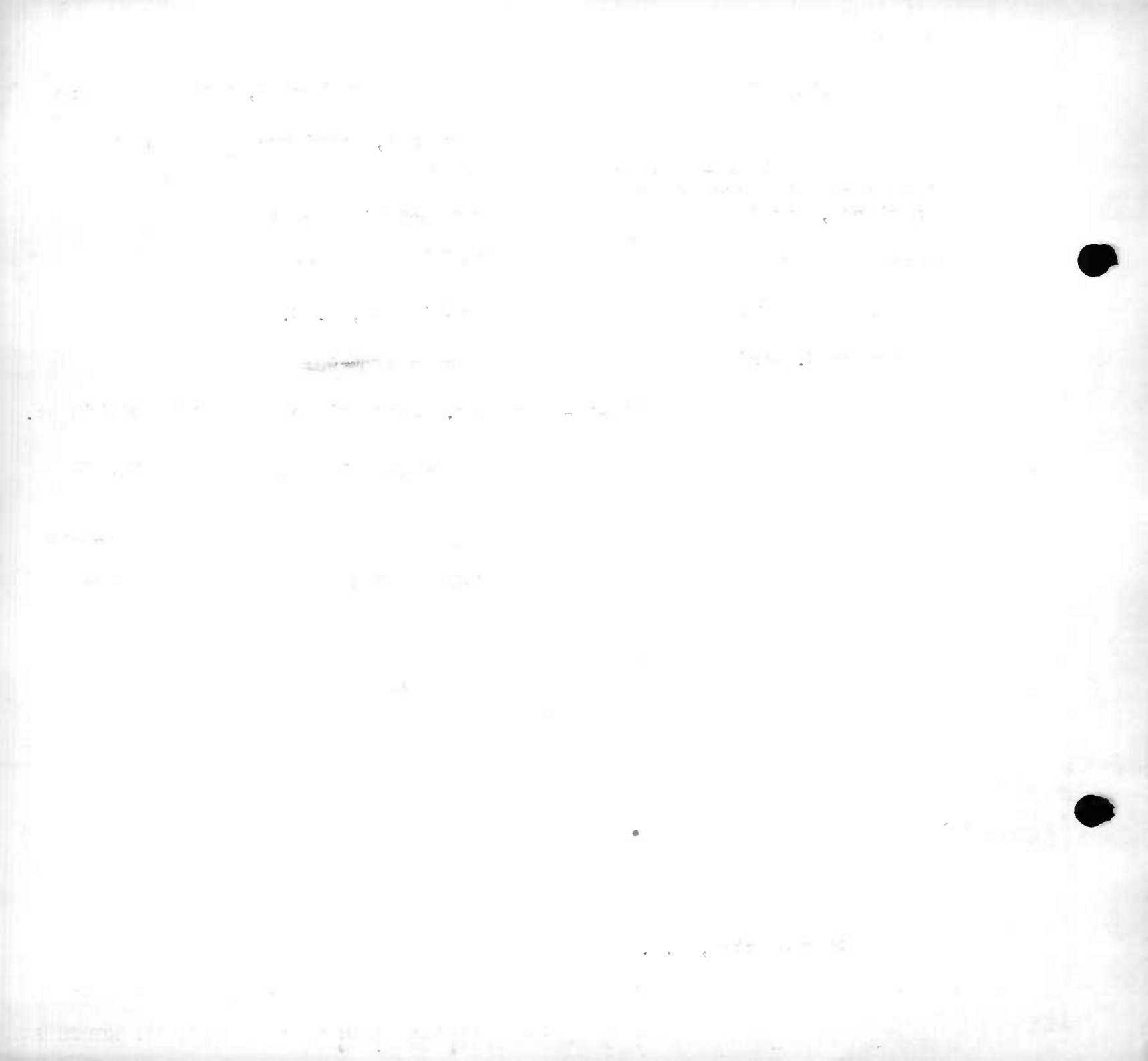
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7-400

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                         |  | REG. NO. <u>72 08749</u>                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                         |  | STATE OF MARYLAND-DHMH                                                                                                                                      |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                               |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                               |  |                                                                                                                                                             |
| ALICE WILSON                                                                                                                                                                                                                                                                                                                         |  | September 12, 1972 4:00A M.                                                                                                                                                             |  |                                                                                                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                         |  |                                                                                                                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                   |  |                                                                                                                                                             |
| HOUSE IN THE PINES - BELVEDERE<br>2525 West Belvedere Avenue<br>Baltimore, Maryland 21215                                                                                                                                                                                                                                            |  | Maryland, Baltimore<br>C. CITY OR TOWN<br>Baltimore<br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |                                                                                                                                                             |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                     |  | 6. RACE<br>Negro                                                                                                                                                                        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                          |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                       |  | 8. DATE OF BIRTH<br>2/25/1899                                                                                                                               |
| Teacher-Housewife                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                         |  | 9. AGE (In years last birthday)<br>73                                                                                                                       |
| 13. FATHER'S NAME<br>Clarence C. Waring                                                                                                                                                                                                                                                                                              |  | 14. MOTHER'S MAIDEN NAME<br>Frances Deaver                                                                                                                                              |  |                                                                                                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                       |  | 16. SOCIAL SECURITY NO.<br>212-38-0495B                                                                                                                                                 |  | 17. INFORMANT<br>Mr. Edward Wilson                                                                                                                          |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>BRONCHO PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) GANGRENE LEFT FOOT<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) ARTERIC SCLEROTIC CVD |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS<br>6 Months<br>Years                                                                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                               |  |                                                                                                                                                                                         |  |                                                                                                                                                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                        |  | 20A. AUTOPSY? (Yes or No)<br>NO                                                                                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                            |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                  |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                  |  |                                                                                                                                                                                         |  |                                                                                                                                                             |
| 23A. SIGNATURE<br>Conrad Action                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                         |  | 23B. DATE SIGNED<br>12 SEP 72                                                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br>Conrad Action, M.D.                                                                                                                                                                                                                                                                                  |  | 23D. ADDRESS                                                                                                                                                                            |  |                                                                                                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br>9-16-72                                                                                                                                                                    |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Park                                                                                                 |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR<br>Ludwig W. W. W.                                                                                                                                               |  | 25C. FUNERAL DIRECTOR<br>NUTTER FUNERAL HOME 3035 W. NORTH AVE                                                                                              |





72 08750

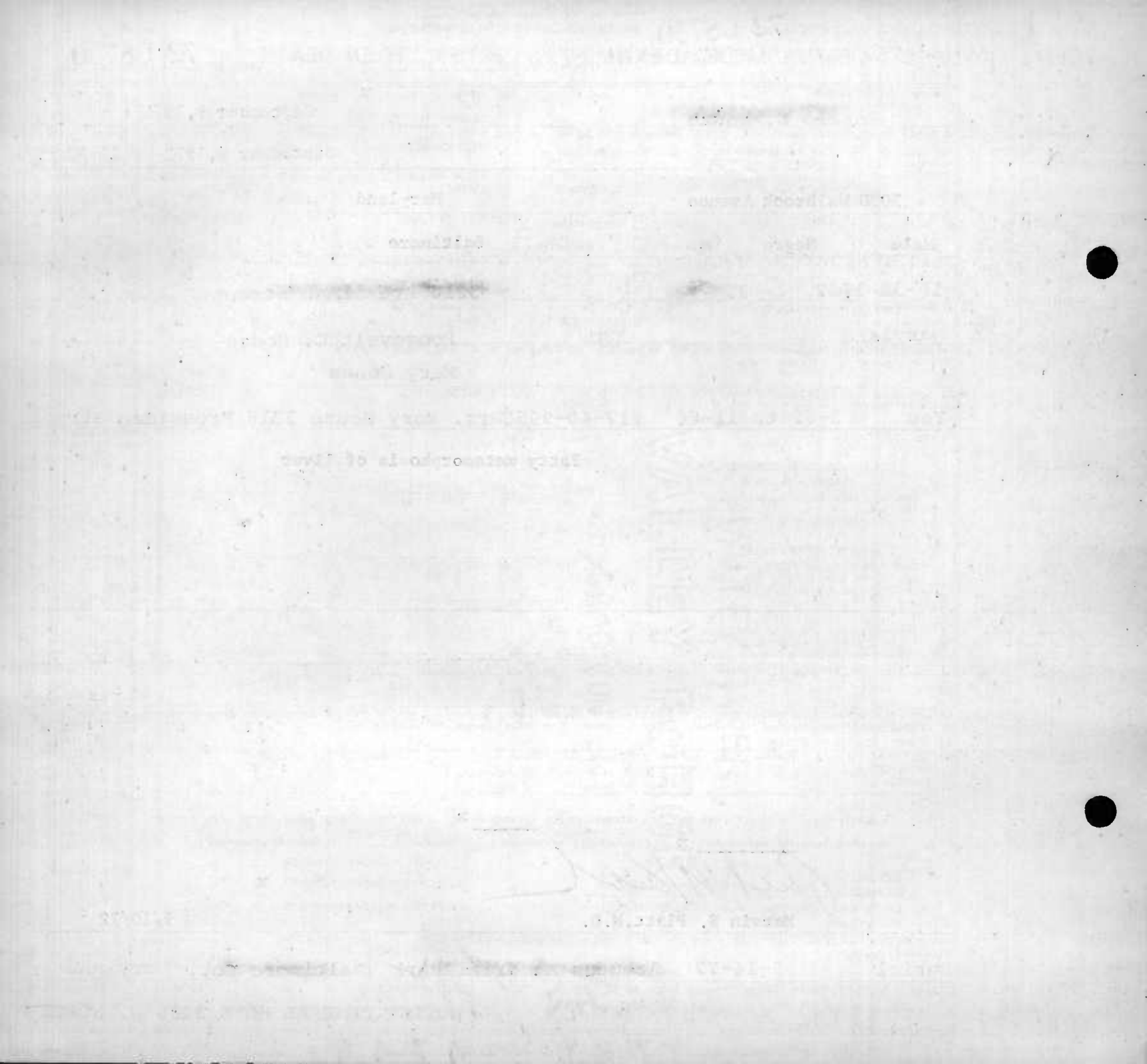
STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08750

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Ronald E. Houze                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> September 9, 1972<br>M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>00 3000 Walbrook Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>September 9, 1972 11:20 P.M.                                                             |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7. RACE<br>Negro                                                                                          |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1607                  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | C. CITY OR TOWN<br>Baltimore                                                                              |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                              |  |
| 9. DATE OF BIRTH<br>10-30-1942                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10. AGE (In years last birthday)<br>29                                                                    |  | E. STREET AND NUMBER<br>3216 Presstman Street                                                                                              |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                       |  | 13. FATHER'S NAME<br>Roosevelt C. Houze                                                                                                    |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>Mary Jones                                                                                                     |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes 2-62 to 11-66                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 17. SOCIAL SECURITY NO.<br>217-40-9958                                                                    |  | 18. INFORMANT<br>Mrs. Mary Houze 3216 Presstman Street                                                                                     |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Fatty metamorphosis of liver<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                       |  |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                               |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 21. AUTOPSY? (Yes or No)<br>yes                                                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                   |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?                                                                                                                 |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>Marvin S. Platt</i> M.D.<br>EXAMINER'S NAME (Type) Marvin S. Platt, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 9/10/72 |  |                                                                                                           |  |                                                                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 24B. DATE<br>9-14-72                                                                                      |  | 24C. NAME of CEMETERY or CREMATORY<br>Arbutus Memorial Park                                                                                |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore Co., Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                            |  | 25B. NAME OF REGISTRAR<br><i>Sidney Houston</i>                                                                                            |  |
| 25C. FUNERAL DIRECTOR<br>NUTTER FUNERAL HOME 3035 W. NORTH AV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25D. ADDRESS                                                                                              |  |                                                                                                                                            |  |



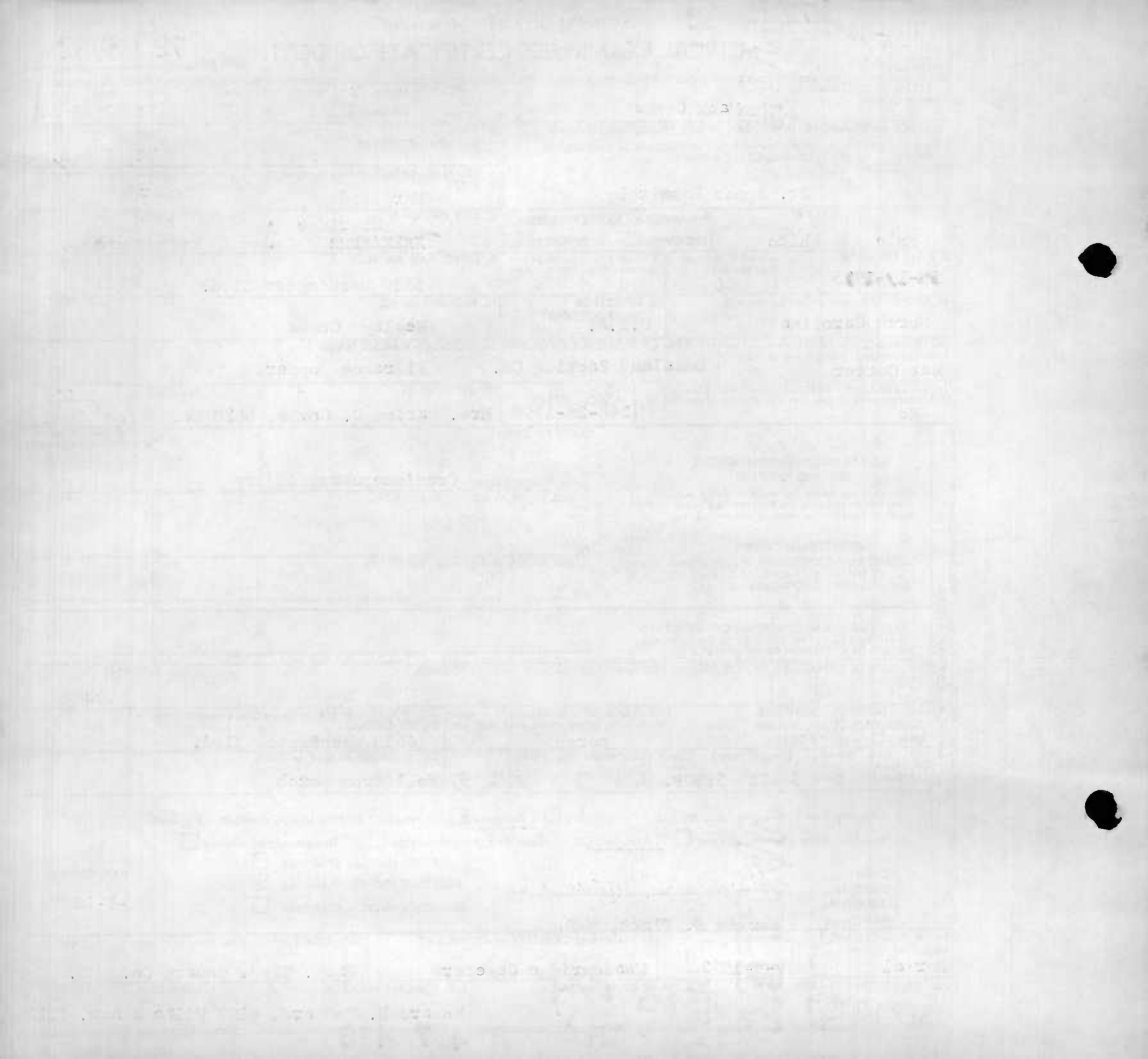
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |                                                                                                                                                          | REG. NO. 72 08751                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--|
| B-231 72 08751                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |                                                                                                                                                          | STATE OF MARYLAND - DUMFRIES                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Joseph Restivo</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                        | 2. DATE AND HOUR OF DEATH<br><b>9/6/72</b> M.                                                                                                            |                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 Caton Manor Nursing Home</b>                                                                                                                                         |  |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore City</b> <b>2720</b> |                                                                          |  |
| 5. SEX <b>Male</b> 6. RACE <b>White</b> 7. <del>MARRIED</del> <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <input type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>                                                                                                          |  |                                                                                                        | 8. DATE OF BIRTH <b>Feb. 17, 1874</b> 9. AGE (In years last birthday) <b>98</b>                                                                          |                                                                          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>                                                                                                                                                                                                                                            |  |                                                                                                        | 10B. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Foods</b>                                                                                                 |                                                                          |  |
| 11. BIRTHPLACE (State or foreign country) <b>Italy</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                               |                                                                          |  |
| 13. FATHER'S NAME <b>Phillip Restivo</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 14. MOTHER'S MAIDEN NAME <b>Theresa (Unknown)</b>                                                                                                        |                                                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>                                                                                                                                                                                                                                    |  |                                                                                                        | 16. SOCIAL SECURITY NO. <b>218-54-0807</b>                                                                                                               |                                                                          |  |
| 17. INFORMANT <b>Paul S. Restivo, 3903 Brookhill Rd. Balto.</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                        | ADDRESS                                                                                                                                                  |                                                                          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Ca. Prostate &amp; Bladder</b>                                                                                                               |  |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Undetermined</b>                                                                                         |                                                                          |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Smudged Carcinomas</b>                                                                                                                                                                                           |  |                                                                                                        | 6 mos.                                                                                                                                                   |                                                                          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Secondary Omenia</b>                                                                                                                                                                                     |  |                                                                                                        | Undetermined.                                                                                                                                            |                                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                                          | 20A. AUTOPSY? (Yes or No)                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                 |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                                                                                                                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                             |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                                          | 21F. HOW DID INJURY OCCUR?                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7/29</b> 19 <b>72</b> to <b>9/5</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9/5</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |                                                                                                                                                          |                                                                          |  |
| 23A. SIGNATURE <b>Charles J. Tommasello</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                                                                                                                                          | 23B. DATE SIGNED <b>Sept 8/72</b>                                        |  |
| 23C. PHYSICIAN'S NAME <b>Charles J. Tommasello</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |                                                                                                                                                          | 23D. ADDRESS <b>910 W. Lombard St</b>                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                              |  | 24B. DATE                                                                                              |                                                                                                                                                          | 24C. NAME OF CEMETERY or CREMATORY                                       |  |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                                                         |  | <b>9/10/72</b>                                                                                         |                                                                                                                                                          | <b>New Cathedral</b>                                                     |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR                                                                                 |                                                                                                                                                          | 25C. FUNERAL DIRECTOR                                                    |  |
| <b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                    |  | <b>Sidney M. Hubbard</b>                                                                               |                                                                                                                                                          | <b>Howard H. Hubbard, 4;07 Wilkens Ave. 21220</b>                        |  |



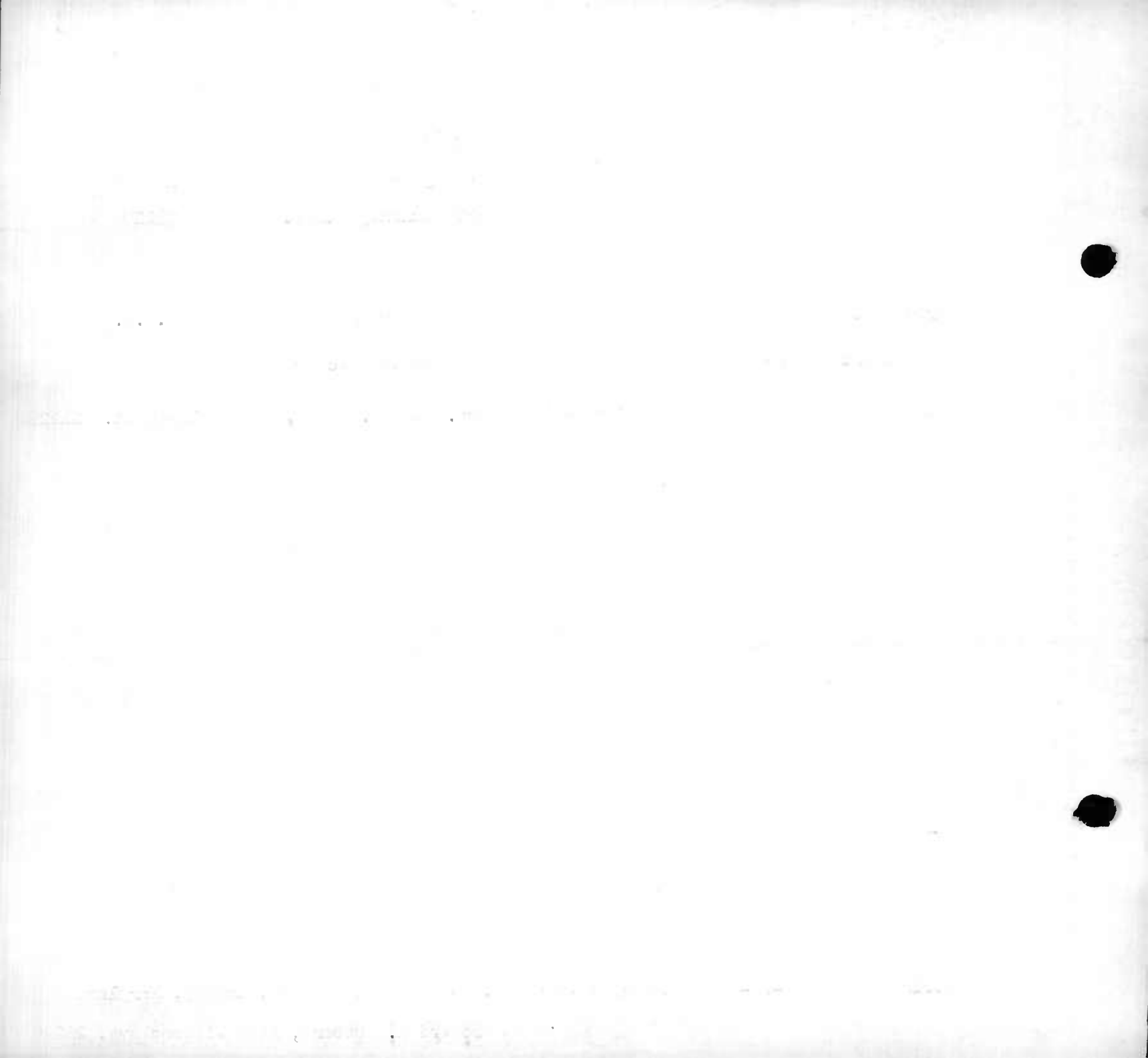
| STATE OF MARYLAND-DEMH<br>BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                        |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                   |  |                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                        |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                   |  | REG. NO. 72 08752                 |  |
| BIRTH NO. C-512                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                        |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                   |  |                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print) John Mack Combs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                        |  |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 6 Year 72 Hour 7:45 A.M. |                                                                                                   |  |                                   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>St. Agnes Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                        |  |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 6 Year 72 Hour 7:45A. M.                                                                       |                                                                                                   |  |                                   |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland B. COUNTY Howard                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                        |  |                                                                                                                                                             | C. CITY OR TOWN Elkridge D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |                                                                                                   |  |                                   |  |
| 6. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7. RACE White                          |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                       | E. STREET AND NUMBER<br>6620 Washington Blvd.                                                     |  |                                   |  |
| 9. DATE OF BIRTH<br>10-13-1925                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10. AGE (In years last birthday)<br>46 |  | 11. BIRTHPLACE (State or foreign country)<br>North Carolina                                                                                                 |                                                                                                                                       | 12. CITIZEN OF<br>U.S.A.                                                                          |  | 13. FATHER'S NAME<br>Wesley Combs |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Meat Cutter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                        |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Dukeland Packing Co.                                                                                                   |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>Florence Hoppers                                                      |  |                                   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                        |  | 17. SOCIAL SECURITY NO.<br>246-28-1798                                                                                                                      |                                                                                                                                       | 18. INFORMANT ADDRESS<br>Mrs. Marion V. Combs, 6620 Washinton Blvd. 21227                         |  |                                   |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                             |  |                                        |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                   |  |                                   |  |
| 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                        |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                   |  |                                   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                        |  | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)<br>porch                                                           |                                                                                                                                       | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>6620 Washington Blvd. |  |                                   |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br>9 5 72 5:30P.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                        |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                        |                                                                                                                                       | 22F. HOW DID INJURY OCCUR?<br>fell from porch                                                     |  |                                   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>Marvin S. Platt, M.D.</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9-7-72<br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |                                        |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                   |  |                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24B. DATE<br>9-9-1972                  |  | 24C. NAME OF CEMETERY or CREMATORY<br>Meadowridge Cemetery                                                                                                  |                                                                                                                                       | 24D. LOCATION (City, town, or county) (State)<br>Wash. Blvd. Howard Co., Md.                      |  |                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                        |  | 25B. NAME OF REGISTRAR<br><i>Sidney M. ...</i>                                                                                                              |                                                                                                                                       | 25C. FUNERAL DIRECTOR ADDRESS<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229                       |  |                                   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-650                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     | 72 08753                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                              |                                              | 72 08753                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | 72 08753                                                                                                                                                    |  | CERTIFICATE OF DEATH                                                                                                                                                                          |                                              | REG. NO.                                                                                         |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Charles Joseph Brown</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><i>9/7/72 4:30 A.M.</i>                                                                                                                                          |                                              |                                                                                                  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>University of Maryland</i><br><i>38</i>                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY <i>2551</i>                                                    |                                              |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                                                           |                                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  | E. STREET AND NUMBER<br><i>3379 Dulaney Street</i>                                                                                                                                            |                                              | 21229                                                                                            |  |
| 5. SEX<br><i>M</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>12-21-20</i>                                                                                                                                                           | 9. AGE (In years last birthday)<br><i>51</i> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.                                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Trans &amp; traffic</i>                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                             |                                              | 11. BIRTHPLACE (State or foreign country)<br><i>New Jersey</i>                                   |  |
| 13. FATHER'S NAME<br><i>Robert Brown</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><i>Blanche Schcroft</i>                                                                                                                                           |                                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>Yes W W II</i>                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br><i>220-07-2011</i>                                                                                                                                                 |                                              | 17. INFORMANT<br><i>Mrs. Anna E. Brown, 3379 Dulaney St. 21229</i>                               |  |
| 18. CAUSE OF DEATH<br><i>729.1 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><i>II</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><i>Emphysema</i> |                     |                                                                                                                                                             |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Myocardial Infarction</i><br><br>(B) <i>Post Op Anterior Cervical Fusion</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 hr.</i><br><i>2 days</i><br><i>2-3 yrs.</i> |  |
| 19A. DATE OF OPERATION<br><i>3/5/72</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                              |                                              | 20A. AUTOPSY? (Yes or No)<br><i>yes</i>                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                      |                                              | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)<br><i>9/7/72</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                     |                                              | 21F. HOW DID INJURY OCCUR?                                                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/28</i> 19 <i>72</i> to <i>9/7</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>9/7</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                   |                     |                                                                                                                                                             |  |                                                                                                                                                                                               |                                              |                                                                                                  |  |
| 23A. SIGNATURE<br><i>H. Ziegler M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |  | 23B. DATE SIGNED<br><i>9/7/72</i>                                                                                                                                                             |                                              | 23C. PHYSICIAN'S NAME (Type)<br><i>J. H. Ziegler, M.D.</i>                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                             |  | 24B. DATE<br><i>9-11-1972</i>                                                                                                                                                                 |                                              | 24C. NAME OF CEMETERY or CREMATORY<br><i>Dulaney Valley Mem. Gardens</i>                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 13 1972</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |  | 25B. NAME OF REGISTRAR<br><i>Howard H. Hubbard</i>                                                                                                                                            |                                              | 25C. FUNERAL DIRECTOR<br><i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>                       |  |





MAK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                            |  |                      |  |                                                                                              |  |                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| S-156                                                                                                                                                                                                                                                                                                                      |  | 72 08754             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                             |  | 72 08754                                                                              |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                  |  | 1. NAME OF DECEASED  |  | 2. DATE AND HOUR OF DEATH                                                                    |  | REG. NO.                                                                              |  |
| (Type or Print)                                                                                                                                                                                                                                                                                                            |  | SCHOEFFNER, INEZ MAE |  | September 7, 1972                                                                            |  | STATE OF MARYLAND - DEMO                                                              |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                     |  |                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)        |  |                                                                                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                  |  |                      |  | A. STATE                                                                                     |  | B. COUNTY                                                                             |  |
| ST AGNES HOSPITAL                                                                                                                                                                                                                                                                                                          |  |                      |  | MARYLAND                                                                                     |  | BALTIMORE                                                                             |  |
| 40                                                                                                                                                                                                                                                                                                                         |  |                      |  | C. CITY OR TOWN                                                                              |  | D. INSIDE CITY LIMITS?                                                                |  |
| 9-19-72                                                                                                                                                                                                                                                                                                                    |  |                      |  | BALTIMORE                                                                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                     |  |                      |  | 6. RACE                                                                                      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| FEMALE                                                                                                                                                                                                                                                                                                                     |  |                      |  | CAUCASIAN                                                                                    |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                |  |                      |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                            |  | 8. DATE OF BIRTH                                                                      |  |
| HOUSEWIFE                                                                                                                                                                                                                                                                                                                  |  |                      |  |                                                                                              |  | 8/14/89                                                                               |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                          |  |                      |  | 14. MOTHER'S MAIDEN NAME                                                                     |  | 9. AGE (In years last birthday)                                                       |  |
| GEORGE TAYLOR                                                                                                                                                                                                                                                                                                              |  |                      |  | MARY Ann Boswell                                                                             |  | 83                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                   |  |                      |  | 16. SOCIAL SECURITY NO.                                                                      |  | 11. BIRTHPLACE (State or foreign country)                                             |  |
| NO                                                                                                                                                                                                                                                                                                                         |  |                      |  | 220 20 0615                                                                                  |  | MARYLAND                                                                              |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                              |  |                      |  | 12. CITIZEN OF WHAT COUNTRY?                                                                 |  | 13. FATHER'S NAME                                                                     |  |
| CATON & WILKENS AVE                                                                                                                                                                                                                                                                                                        |  |                      |  | U.S.A.                                                                                       |  | W. GEORGE TAYLOR                                                                      |  |
| 21229                                                                                                                                                                                                                                                                                                                      |  |                      |  | 220 20 0615                                                                                  |  | 14. MOTHER'S MAIDEN NAME                                                              |  |
| ST AGNES HOSPITAL BALTIMORE MARYLAND                                                                                                                                                                                                                                                                                       |  |                      |  |                                                                                              |  | MARY Ann Boswell                                                                      |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                         |  |                      |  | CAUSE OF DEATH                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |
| (This does not mean the mode of dying, heart failure, ashenia, etc. If means the disease, injury or complication which caused death)                                                                                                                                                                                       |  |                      |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                          |  | possible pulmonary embolism                                                           |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                          |  |                      |  | (B) ASCD, renal inefficiency                                                                 |  | for months or years                                                                   |  |
| DISEASES OR CONDITIONS, if rise to the above cause (A) UNDERLYING CONDITION last.                                                                                                                                                                                                                                          |  |                      |  | (C)                                                                                          |  |                                                                                       |  |
| II                                                                                                                                                                                                                                                                                                                         |  |                      |  | subcapital fx of Rt hip                                                                      |  | on 8/9/72                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I                                                                                                                                                                                                |  |                      |  | 20A. AUTOPSY? (Yes or No)                                                                    |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |  |                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                             |  | 20A. AUTOPSY? (Yes or No)                                                             |  |
| 19/1/72                                                                                                                                                                                                                                                                                                                    |  |                      |  | Fair                                                                                         |  | NO                                                                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                      |  |                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
| notified                                                                                                                                                                                                                                                                                                                   |  |                      |  | Home                                                                                         |  | at Home, in Baltimore city                                                            |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                              |  |                      |  | 21E. INJURY OCCURRED                                                                         |  | 21F. HOW DID INJURY OCCUR?                                                            |  |
| Aug 29 1972 6:45 AM                                                                                                                                                                                                                                                                                                        |  |                      |  | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> |  | Fell in bathroom of home                                                              |  |
| 22. I certify that (X) (this hospital) attended the deceased from AUGUST 29 1972 to SEPTEMBER 7 1972, that (X) (we) last saw the deceased alive on SEPTEMBER 7 1972 and that in (XXX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. |  |                      |  |                                                                                              |  |                                                                                       |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                             |  |                      |  | 23B. DATE SIGNED                                                                             |  | 23C. PHYSICIAN'S NAME (Type)                                                          |  |
| Tee-shiung Wu, M.D.                                                                                                                                                                                                                                                                                                        |  |                      |  | 9/7/72                                                                                       |  | Tee-shiung Wu, M.D.                                                                   |  |
| 23D. ADDRESS                                                                                                                                                                                                                                                                                                               |  |                      |  | 23E. FUNERAL DIRECTOR                                                                        |  | 23F. ADDRESS                                                                          |  |
| WILKENS AVE 21229                                                                                                                                                                                                                                                                                                          |  |                      |  | HUBBARD H. HUBBARD                                                                           |  | 4107 Wilkens Ave. 21229                                                               |  |
| ST AGNES HOSPITAL RECORD'S CATON &                                                                                                                                                                                                                                                                                         |  |                      |  |                                                                                              |  |                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                   |  |                      |  | 24B. DATE                                                                                    |  | 24C. NAME OF CEMETERY or CREMATORY                                                    |  |
| Burial                                                                                                                                                                                                                                                                                                                     |  |                      |  | 9-12-1972                                                                                    |  | London Park Cemetery                                                                  |  |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                              |  |                      |  | 24E. DATE REC'D BY HEALTH DEPT.                                                              |  | 24F. NAME OF REGISTRAR                                                                |  |
| Baltimore, Maryland                                                                                                                                                                                                                                                                                                        |  |                      |  | SEP 13 1972                                                                                  |  | Sidney Hubbard                                                                        |  |

9-19-1972 --- Correction letter from St. Agnes Hospital, Balto., Md.

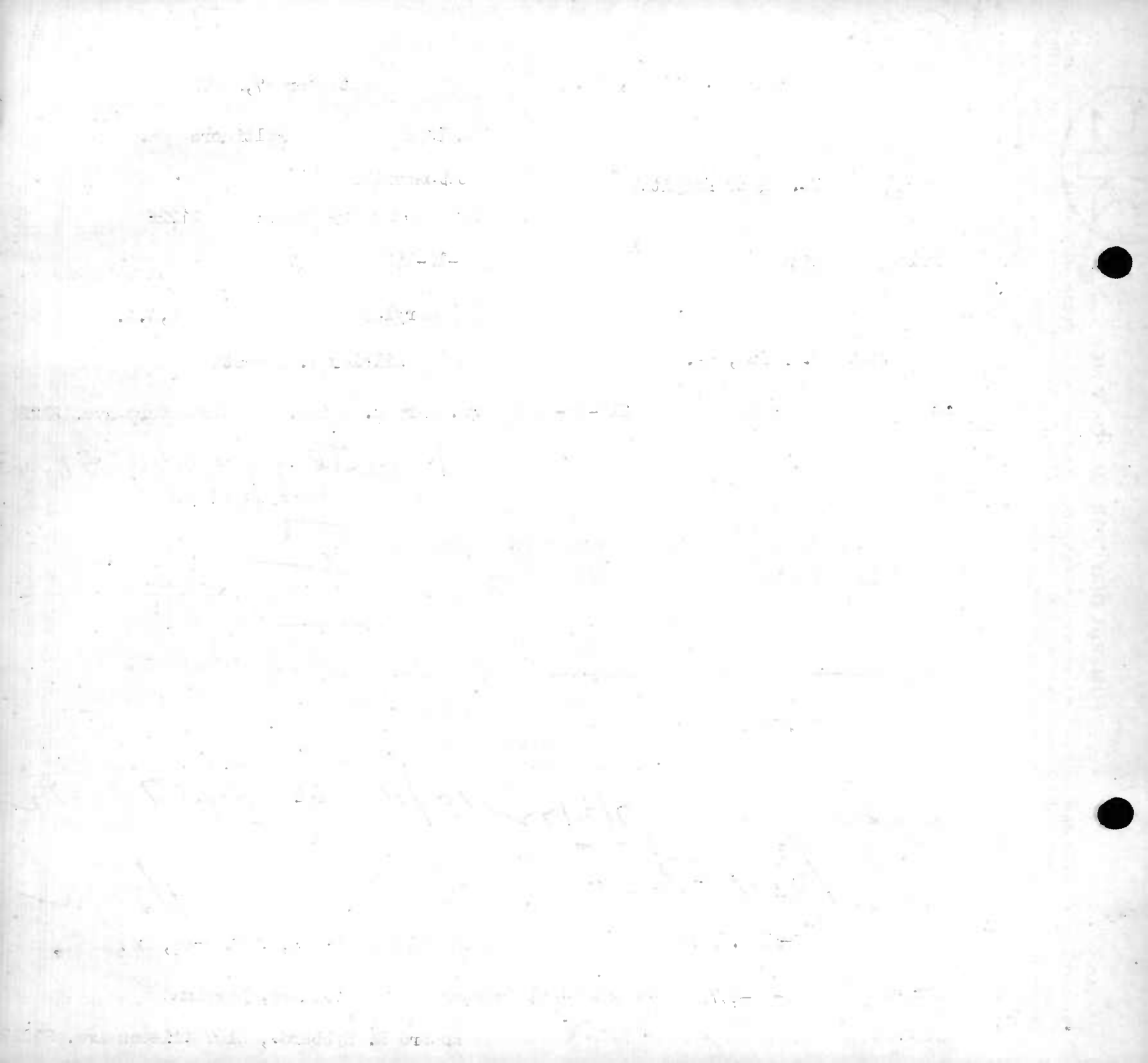
signed by Paul Coakley, Director, Admissions and Communications.

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                                    |                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                         |                                                                                                           | REG. NO. 72 08755                                                                                                                                                  |                                                                      |
| 72 08755                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 72 08755                                                                                                                                                           |                                                                      |
| BIRTH NO. S-530                                                                                                                                                                                                                                                                                                                          |                                                                                                           | STATE OF MARYLAND-DEM                                                                                                                                              |                                                                      |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                   |                                                                                                           | 2. DATE AND HOUR OF DEATH                                                                                                                                          |                                                                      |
| JAMES W. SMITH, JR.                                                                                                                                                                                                                                                                                                                      |                                                                                                           | September 7, 1972                                                                                                                                                  |                                                                      |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                   |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                              |                                                                      |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>40 St. Agnes Hospital                                                                                                                                                                                                                                                                        |                                                                                                           | A. STATE<br>Maryland                                                                                                                                               |                                                                      |
|                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | B. COUNTY<br>Baltimore                                                                                                                                             |                                                                      |
| C. CITY OR TOWN<br>Catonsville                                                                                                                                                                                                                                                                                                           |                                                                                                           | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                      |                                                                      |
|                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | E. STREET AND NUMBER<br>402 Bloomsbury Avenue 21228                                                                                                                |                                                                      |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                           | 6. RACE<br>White                                                                                          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        | 8. DATE OF BIRTH<br>9-12-1924                                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                              |                                                                                                           | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                  | 9. AGE (In years last birthday)<br>47                                |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                    |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                             |                                                                      |
| 13. FATHER'S NAME<br>James W. Smith, Sr.                                                                                                                                                                                                                                                                                                 |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br>Lillian V. Bennett                                                                                                                     |                                                                      |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes                                                                                                                                                                                                                          |                                                                                                           | 16. SOCIAL SECURITY NO.<br>219-12-6662                                                                                                                             | 17. INFORMANT<br>Mrs. Mary B. Smith, 402 Bloomsbury Ave. 21228       |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                                                                                                           | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Acute myocardial infarction</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                      |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                                    |                                                                      |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          | 20A. AUTOPSY? (Yes or No)                                                                                                                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                        |                                                                      |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                            | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                         |                                                                      |
| 22. I certify that (I) (this hospital) attended the deceased from 10/4 1966 to Sept 7 1972.<br>that (I) (we) last saw the deceased alive on 7/3/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                           |                                                                                                           |                                                                                                                                                                    |                                                                      |
| 23A. SIGNATURE<br><i>Earl I. Pass</i>                                                                                                                                                                                                                                                                                                    |                                                                                                           | 23B. DATE SIGNED<br>9/9/72                                                                                                                                         |                                                                      |
| 23C. PHYSICIAN'S NAME (Type)<br>Earl I. Pass                                                                                                                                                                                                                                                                                             |                                                                                                           | 23D. ADDRESS<br>4001 Wilkens Avenue, Baltimore, Md.                                                                                                                |                                                                      |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                       | 24B. DATE<br>9-11-1972                                                                                    | 24C. NAME of CEMETERY or CREMATORY<br>New Cathedral Cemetery                                                                                                       | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                           | 25B. NAME OF REGISTRAR<br><i>Edward H. Hubbard</i>                                                        | 25C. FUNERAL DIRECTOR<br>Edward H. Hubbard, 4107 Wilkens Ave. 21229                                                                                                | ADDRESS                                                              |



B-620

72 08756 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08756

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                           |  |                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |  | 1. NAME OF DECEASED<br>(Type or Print) <b>CHARLESE BRAGG</b>                                                                                                              |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Month Day Year                                   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 3710 Fourth Street</b>                                                                                                                                                                                                                                                                                |  | 3. DATE PRONOUNCED DEAD<br><b>September 9, 1972</b>                                                                                                                       |  | Hour <b>10:10 P.M.</b>                                                                                                                                   |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2534</b>                                                                                                                                                                                                                                                                       |  | 6. SEX <b>Male</b> 7. RACE <b>White</b>                                                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>March 3, 1938</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years last birthday) <b>34</b>                                                                                                                                |  | 11. BIRTHPLACE (State or foreign country)<br><b>Grand Rapids, Mich</b>                                                                                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 13. FATHER'S NAME<br><b>Fordyce Bragg</b>                                                                                                                                 |  | 14. STREET AND NUMBER<br><b>3710 Fourth Street</b>                                                                                                       |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Florine Bragg</b>                                                                                                                                                                                                                                                                                                                                                              |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes</b>                                                     |  | 17. SOCIAL SECURITY NO.                                                                                                                                  |  |
| 18. INFORMANT<br><b>Fordyce Bragg</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 19. CAUSE OF DEATH<br><b>Malignant Hypertension</b>                                                                                                                       |  | 20. ADDRESS<br><b>6600 Dennison Road</b>                                                                                                                 |  |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>400.0, Dundee Mich</b>                                                                                                                                                                                 |  | 22. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                        |  | 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                     |  |
| 24A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 24B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                          |  | 24C. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                  |  |
| 25A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, allie bldg., etc.)                                                                                   |  | 25C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                 |  |
| 25D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                     |  | 25E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                    |  | 25F. HOW DID INJURY OCCUR?                                                                                                                               |  |
| 26. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                           |  |                                                                                                                                                          |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                       |  | Deputy Chief Medical Examiner <input checked="" type="checkbox"/> Assistant Medical Examiner <input type="checkbox"/> Associate Medical Examiner <input type="checkbox"/> |  | DATE SIGNED<br><b>9/10/72</b>                                                                                                                            |  |
| 27A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  | 27B. DATE<br><b>9/13/72</b>                                                                                                                                               |  | 27C. NAME of CEMETERY or CREMATORY<br><b>Ridgeway Cemetery</b>                                                                                           |  |
| 27D. LOCATION (City, town, or county) (State)<br><b>Ridgeway, Michigan</b>                                                                                                                                                                                                                                                                                                                                    |  | 27E. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                     |  | 27F. NAME OF REGISTRAR<br><b>George J. Gonce</b>                                                                                                         |  |
| 27G. FUNERAL DIRECTOR<br><b>George J. Gonce</b>                                                                                                                                                                                                                                                                                                                                                               |  | 27H. ADDRESS<br><b>4001 Ritchie Highway</b>                                                                                                                               |  | 27I. ADDRESS<br><b>Balto, Maryland</b>                                                                                                                   |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                  |  |                                                                                          |  | 72 08757                                                                                                                                                    |  | 12 08757                                                                                                                                                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. <u>4-630</u>                                                                                                                                                                                                            |  |                                                                                          |  | REG. NO. <u>72 08757</u>                                                                                                                                    |  |                                                                                                                                                                                                                                |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Holly Christen</u>                                                                                                                                                                      |  |                                                                                          |  | 2. DATE AND HOUR OF DEATH<br><u>9/10/72</u> <u>1</u> <u>2</u> <u>P</u> M.                                                                                   |  |                                                                                                                                                                                                                                |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><u>Baby Girl Howard</u>                                                                                                                                                 |  |                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>4015200</u>               |  |                                                                                                                                                                                                                                |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>43 SB64</u>                                                                                                                                                                            |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                     |  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                         |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                  |  |
| 5. SEX<br><u>F</u>                                                                                                                                                                                                                |  | 6. RACE<br><u>Caucasian</u>                                                              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>9/10/72</u>                                                                                                                                                                                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>                                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 9. AGE (in years last birthday)<br><u>4</u>                                                                                                                 |  | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>                                                                                                                                                                     |  |
| 13. FATHER'S NAME<br><u>Dale Harley Howard</u>                                                                                                                                                                                    |  | 14. MOTHER'S MAIDEN NAME<br><u>Margaret Catherine Gunkel</u>                             |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>                                                                                                                 |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                          |  |
| 16. SOCIAL SECURITY NO.<br><u>None</u>                                                                                                                                                                                            |  | 17. INFORMANT<br><u>Dale Howard</u>                                                      |  | 18. ADDRESS<br><u>504 Wood Street</u>                                                                                                                       |  | 19. DATE OF BIRTH<br><u>9/10/72</u>                                                                                                                                                                                            |  |
| 18. CAUSE OF DEATH<br><u>776.1 I</u>                                                                                                                                                                                              |  |                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4</u>                                                                                                    |  |                                                                                                                                                                                                                                |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Hyaline Membrane Disease</u> |  |                                                                                          |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                         |  |                                                                                                                                                                                                                                |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Prematurity</u>                                                                              |  |                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |  |                                                                                                                                                                                                                                |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>II</u>                                                                                     |  |                                                                                          |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |  |                                                                                                                                                                                                                                |  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)<br><u>NO</u>                                                                                                                      |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>NO</u>                                                                                                                                              |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                 |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                 |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                      |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                         |  | 21F. HOW DID INJURY OCCUR?                                                               |  | 22. I certify that (I) (this hospital) attended the deceased from <u>9/10 9:55 AM</u> to <u>9/10 2 PM</u> 19 <u>72</u>                                      |  | that (I) (we) last saw the deceased alive on <u>9/10</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |
| 23A. SIGNATURE<br><u>James A. Kopper m.d.</u>                                                                                                                                                                                     |  |                                                                                          |  | 23B. DATE SIGNED<br><u>9/10/72</u>                                                                                                                          |  | 23C. PHYSICIAN'S NAME (Type)<br><u>James A. Kopper M.D.</u>                                                                                                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                         |  |                                                                                          |  | 24B. DATE<br><u>9/12/72</u>                                                                                                                                 |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Holy Cross Cemetery</u>                                                                                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 13 1972</u>                                                                                                                                                                             |  |                                                                                          |  | 25B. NAME OF REGISTRAR<br><u>Adney Johnson</u>                                                                                                              |  | 25C. FUNERAL DIRECTOR<br><u>George J. Gonce</u>                                                                                                                                                                                |  |
| 25D. LOCATION (City, town, or county)<br><u>A.A.Co. Maryland</u>                                                                                                                                                                  |  |                                                                                          |  | 25E. ADDRESS<br><u>4001 Ritchie Hgwy.</u>                                                                                                                   |  |                                                                                                                                                                                                                                |  |

Address verified with hospital and correct zone 143.



| STATE OF MARYLAND-DEME                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                       |  |                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| E-655 72 08758                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                |  |                                                                                                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | REG. NO. 72 08758                                                                                                      |  |                                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) EARLENE EARMAN                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Month Day Year |  |                                                                                                                                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>SOUTH BALTO. GENERAL HOSPITAL (DOA)                                                                                                                                                                                                    |  |  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>September 9, 1972 6:45 A.M.                                               |  |                                                                                                                                                             |  |
| 6. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  | 7. RACE<br>White                                                                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>June 30, 1912                                                                                                                                                                                                                                                                                                                                                                             |  |  |  | 10. AGE (In years last birthday)<br>60                                                                                 |  | 11. BIRTHPLACE (State or foreign country)<br>North Carolina                                                                                                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>US                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 13. FATHER'S NAME<br>Andrew J. Rogers                                                                                  |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                     |  |
| 15. MOTHER'S MAIDEN NAME<br>Anna G. Brookshire                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO          |  | 17. SOCIAL SECURITY NO.<br>219 10 4829                                                                                                                      |  |
| 18. INFORMANT<br>Letcher R. Earman                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 19. ADDRESS<br>1430 Light Street                                                                                       |  | 20. DATE OF OPERATION<br>2                                                                                                                                  |  |
| 21. AUTOPSY? (Yes or No)<br>yes                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                |  | 23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                     |  |
| 24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                           |  |  |  | 25. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                            |  | 26. HOW DID INJURY OCCUR?                                                                                                                                   |  |
| 27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  | 28. ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Ronald N. Kornblum, M.D.                                             |  | 29. DATE SIGNED<br>9/9/72                                                                                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 24B. DATE<br>9/12/72                                                                                                   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Cedar Hill Cemetery                                                                                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 25B. NAME OF REGISTRAR<br>Sidney W. Horton                                                                             |  | 25C. FUNERAL DIRECTOR<br>George J. Gonce                                                                                                                    |  |
| 26A. ADDRESS<br>4001 Ritchie Hwy.                                                                                                                                                                                                                                                                                                                                                                             |  |  |  | 26B. ADDRESS<br>4001 Ritchie Hwy.                                                                                      |  | 26C. ADDRESS<br>4001 Ritchie Hwy.                                                                                                                           |  |

10-5-1972 - Completion of cause of death on a pending medical examiner death certificate  
Ronald N. Kornblum, M.D. HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <b>H-300</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                          |  |  |  | REG. NO. <b>72 08759</b>                                                                                 |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-----------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------------------|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>HOOD, MATTIE ELIZABETH</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>SEPTEMBER 11, 1972 9:15 A.M.</b>                                          |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>40 ST AGNES HOSPITAL</b>                    |  |  |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2557</b>                                                                                                                                                                                                                                                                                                                                                  |  |  |  | 5. CITY OR TOWN<br><b>BALTIMORE</b>                                                                       |  |  |  | 6. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 7. STREET AND NUMBER<br><b>CATON MANOR NURSING HOME WILKENS AVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 8. DATE OF BIRTH<br><b>10/02/84</b>                                                                       |  |  |  | 9. AGE (In years last birthday) <b>87</b>                                                                |  |  |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                                                                                                                                              |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>                                        |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                            |  |  |  |
| 13. FATHER'S NAME<br><b>SAMUEL L FORESTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH (</b>                                                            |  |  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>212 03 7084</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | 17. INFORMANT<br><b>ST AGNES HOSPITAL RECORDS CATON &amp; WILKENS AVES BALTO MD 21229</b>                 |  |  |  | ADDRESS                                                                                                  |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute myocardial infarction</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____                                                                                                 |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                              |  |  |  |                                                                                                          |  |  |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Sigmoid Diverticulosis</b>                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                           |  |  |  |                                                                                                          |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                              |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |  |  | 21F. HOW DID INJURY OCCUR?                                                                               |  |  |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>09/11 19 72</b> to <b>09/11 19 72</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>09/11 19 72</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. |  |  |  |                                                                                                           |  |  |  |                                                                                                          |  |  |  |
| 23A. SIGNATURE<br><b>Vincent H. Wang M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | 23B. DATE SIGNED                                                                                          |  |  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>VINCENT WANG, M.D.</b>                                                |  |  |  |
| 23D. ADDRESS<br><b>ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |                                                                                                           |  |  |  |                                                                                                          |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  | 24B. DATE<br><b>9/13/72</b>                                                                               |  |  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>                                           |  |  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                     |  |  |  | 25B. NAME OF REGISTRAR<br><b>Adrian J. [Signature]</b>                                                   |  |  |  |
| 25C. FUNERAL DIRECTOR<br><b>Witzke, 1630 Edmondson Avenue 21228</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | ADDRESS                                                                                                   |  |  |  |                                                                                                          |  |  |  |

8/1/72

6110 Burnt Oak Rd. 21228

| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                    |  | 2. DATE OF DEATH                                                  |  | 3. DATE PRONOUNCED DEAD                 |  | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD |  | 5. USUAL RESIDENCE                                             |  | 6. SEX                                                              |  | 7. RACE                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                             |  | 9. DATE OF BIRTH                                                                                                                 |  | 10. AGE (In years)                       |  | 11. BIRTHPLACE (State or foreign country)        |  | 12. CITIZEN OF WHAT COUNTRY?    |  | 13. FATHER'S NAME                                                                                                    |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  | 15. MOTHER'S MAIDEN NAME                                                 |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |  | 17. SOCIAL SECURITY NO. |  | 18. INFORMANT              |  | ADDRESS                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|-----------------------------------------|--|--------------------------------------------------------|--|----------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------|--|--------------------------------------------------|--|---------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|-------------------------|--|----------------------------|--|---------------------------|--|
| DANIEL ROHE                                                                                                                                                                                                                                                                                                                                                                                               |  | Known <input type="checkbox"/> Estimated <input type="checkbox"/> |  | Month Day Year                          |  | Month Day Year                                         |  | A. STATE B. COUNTY                                             |  | male                                                                |  | white                           |  | <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 7/26/90                                                                                                                          |  | 82                                       |  | Maryland                                         |  | USA                             |  | Charles Rohe                                                                                                         |  | Retired                                                                                    |  | Anna Dougherty                                                           |  |                                                                                                         |  | 212-10-6281             |  | Mrs. Frances Amos          |  | 311 Nottingham Road 21229 |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                                                                                                                                                                                                     |  | A. STATE                                                          |  | B. COUNTY                               |  | C. CITY OR TOWN                                        |  | D. INSIDE CITY LIMITS?                                         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | E. STREET AND NUMBER            |  | F. DATE OF BIRTH                                                                                       |  | G. AGE (In years)                                                                                                                |  | H. BIRTHPLACE (State or foreign country) |  | I. CITIZEN OF WHAT COUNTRY?                      |  | J. FATHER'S NAME                |  | K. MOTHER'S MAIDEN NAME                                                                                              |  | L. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | M. MOTHER'S MAIDEN NAME                                                  |  | N. SOCIAL SECURITY NO.                                                                                  |  | O. INFORMANT            |  | P. ADDRESS                 |  |                           |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                       |  | BALTO                                                             |  | 5300                                    |  | Balto.                                                 |  |                                                                |  |                                                                     |  | 311 Nottingham Rd.              |  |                                                                                                        |  |                                                                                                                                  |  |                                          |  |                                                  |  |                                 |  |                                                                                                                      |  |                                                                                            |  |                                                                          |  |                                                                                                         |  |                         |  |                            |  |                           |  |
| 19. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                        |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                    |  | Arteriosclerotic cardiovascular disease |  | (A) IMMEDIATE CAUSE                                    |  | DUE TO, OR AS A CONSEQUENCE OF:                                |  | (B)                                                                 |  | DUE TO, OR AS A CONSEQUENCE OF: |  | (C)                                                                                                    |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  | 20A. DATE OF OPERATION                   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 21. AUTOPSY? (Yes or No)        |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  | 22D. TIME OF INJURY (APPROX.)                                                                           |  | 22E. INJURY OCCURRED    |  | 22F. HOW DID INJURY OCCUR? |  |                           |  |
| 412.4                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                   |  |                                         |  |                                                        |  |                                                                |  |                                                                     |  |                                 |  |                                                                                                        |  |                                                                                                                                  |  |                                          |  |                                                  |  | no                              |  |                                                                                                                      |  |                                                                                            |  |                                                                          |  |                                                                                                         |  |                         |  |                            |  |                           |  |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | ACTUAL SIGNATURE                                                  |  | EXAMINER'S NAME (Type)                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>        |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                 |  | DATE SIGNED                     |  | 24A. BURIAL CREMATION, REMOVAL (Specify)                                                               |  | 24B. DATE                                                                                                                        |  | 24C. NAME OF CEMETERY or CREMATORY       |  | 24D. LOCATION (City, town, or county) (State)    |  | 25A. DATE REC'D BY HEALTH DEPT. |  | 25B. NAME OF REGISTRAR                                                                                               |  | 25C. FUNERAL DIRECTOR                                                                      |  | ADDRESS                                                                  |  |                                                                                                         |  |                         |  |                            |  |                           |  |
| William P. Mulloy, M.D.                                                                                                                                                                                                                                                                                                                                                                                   |  | 9-11-72                                                           |  | Burial                                  |  | 9/13/72                                                |  | New Cathedral Cemetery                                         |  | Baltimore, Maryland                                                 |  | SEP 13 1972                     |  | Lidny                                                                                                  |  | Witzke, 1630 Edmondson Avenue 21228                                                                                              |  |                                          |  |                                                  |  |                                 |  |                                                                                                                      |  |                                                                                            |  |                                                                          |  |                                                                                                         |  |                         |  |                            |  |                           |  |


Account of the expedition to the  
North Pole, 1894-1895.

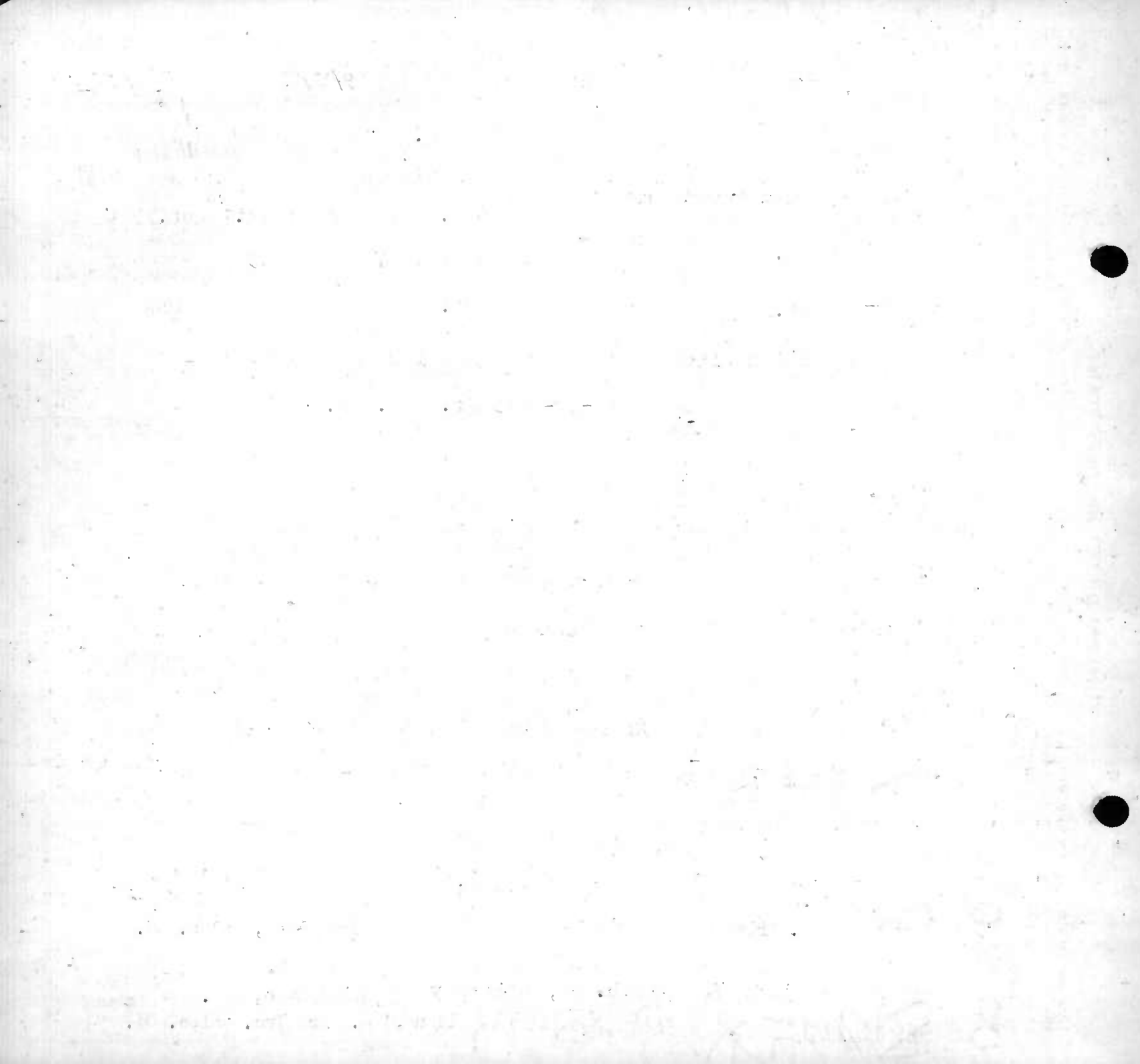
*Dr. J. H. ...*  
...  
...



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                   | REG. NO. 72-08761                                                                                       |                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 72-08761                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                   | STATE OF MARYLAND-DHMH                                                                                  |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) Grace Mitchell Roth                                                                                                                                                                                                                                                                                                                                                                                                                                            |               |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>9/11/72 9:25 A.M.                                                                                                                                                                                                                                                    |                                                                                                         |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>90 Long Green Nursing Home                                                                                                                                                                                                                                                                                                 |               |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 401<br>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 8 E. Pleasant Street Apt. 7 C |                                                                                                         |                                                           |
| 5. SEX F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/17/1887                                                                                                                                                                                                                                                                        | 9. AGE (In years lost birthday) 85                                                                      | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Federal Govt.                                                                                                                                                                                                                                                                                                                                                                                          |               | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 11. BIRTHPLACE (State or foreign country)<br>Md.                                                                                                                                                                                                                                                  |                                                                                                         | 12. CITIZEN OF WHAT COUNTRY?<br>USA                       |
| 13. FATHER'S NAME<br>William Mitchell                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |               |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br>Florence Norwood -                                                                                                                                                                                                                                                    |                                                                                                         |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                        |               | 16. SOCIAL SECURITY NO.<br>216-52-0515                                                                                                                      | 17. INFORMANT ADDRESS<br>Mr. Geo. Wm. Roth same                                                                                                                                                                                                                                                   |                                                                                                         |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)<br>MEDICAL CERTIFICATION |               |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Arteriosclerosis, general<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>Terminal pneumonia, rt middle lobe<br>(C) Fracture of rt hip<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 yrs<br>1 day<br>1 month            |                                                                                                         |                                                           |
| 19A. DATE OF OPERATION<br>8-6-72                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                   | 20A. AUTOPSY? (Yes or No)<br>No                                                                         |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                        |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Nursing home                                                    |                                                                                                                                                                                                                                                                                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>115 E. Melrose - BALTO 2712 |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>8-6-72 8:30 PM                                                                                                                                                                                                                                                                                                                                                                                                                           |               | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                        |                                                                                                                                                                                                                                                                                                   | 21F. HOW DID INJURY OCCUR?<br>Slipped out of bottom of bed                                              |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from 5/6/1955 to 9-11-1972, that (I) (we) last saw the deceased alive on 9-11-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.                                                                                                                                                                                                    |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                           |
| 23A. SIGNATURE<br><br>DEGREE MD                                                                                                                                                                                                                                                                                                                                                                                    |               |                                                                                                                                                             | 23B. DATE SIGNED<br>9-11-72                                                                                                                                                                                                                                                                       |                                                                                                         | 23C. PHYSICIAN'S NAME (Type)<br>M. Friedman               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               |                                                                                                                                                             | 24B. DATE<br>9/15/72                                                                                                                                                                                                                                                                              |                                                                                                         | 24C. NAME OF CEMETERY or CREMATORY<br>Baltimore, Cemetery |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br>Leonard J. Ruck Inc.                                                                                                                                                                                                                                                    |                                                                                                         | 25C. FUNERAL DIRECTOR ADDRESS<br>Balto. Md.               |

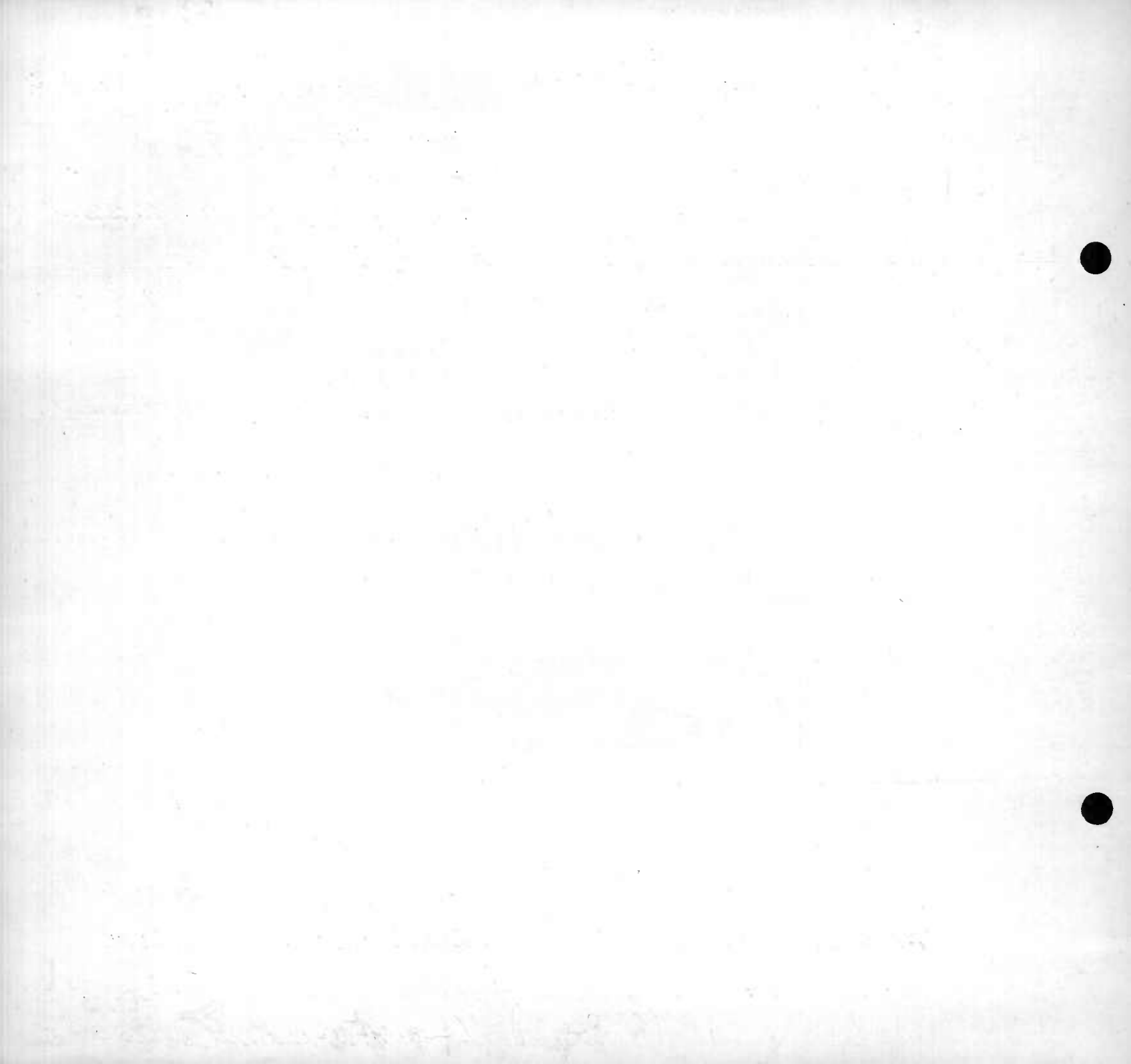




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

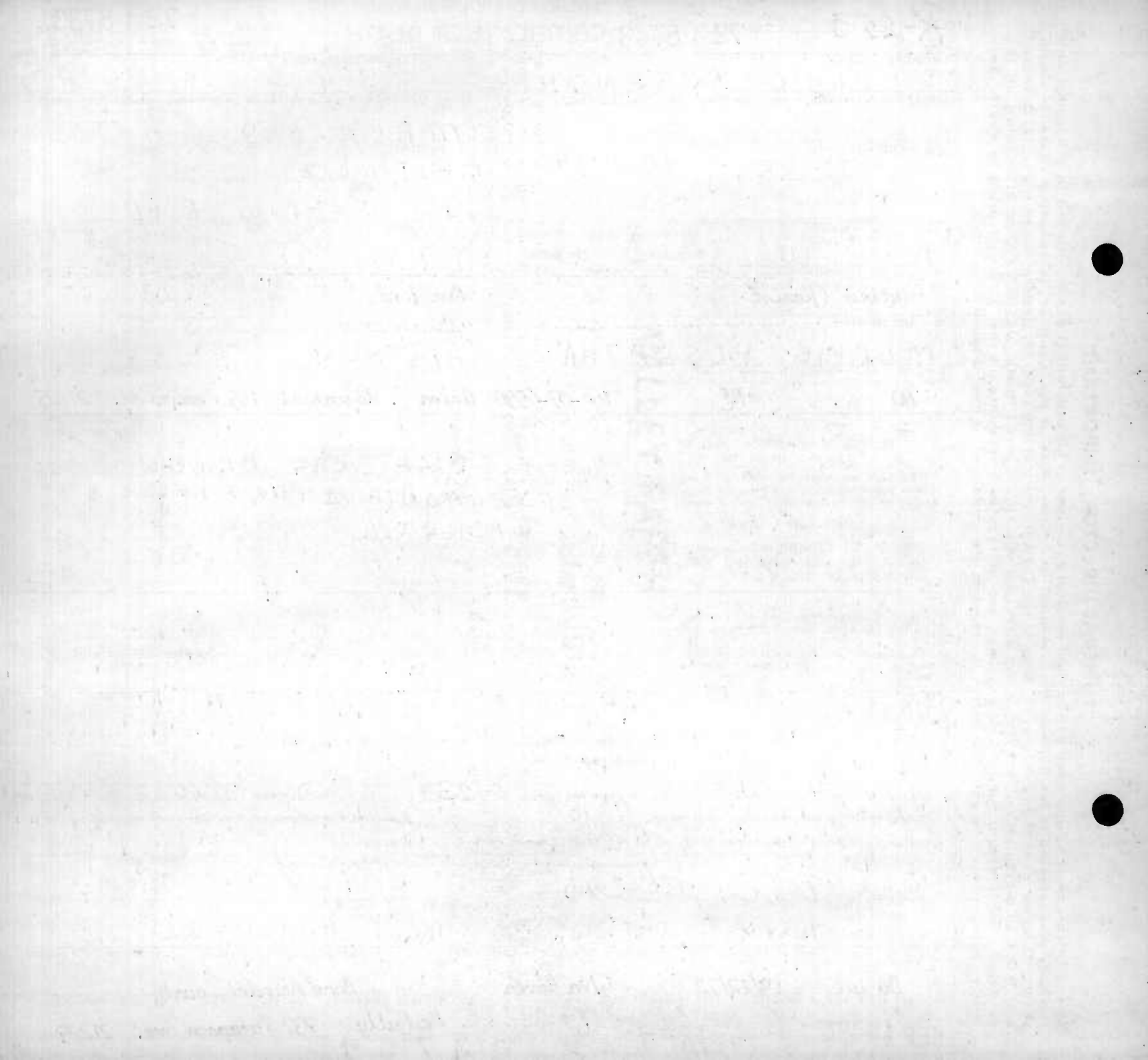
|                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                       |  |
|--------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                             |  | 72 08762                                                                                                                                     |  | 72 08762                                                                                                                                                    |  | REG. NO.                                                                                                                                                                                                                                                                                              |  |
| BIRTH NO.                                                                                                    |  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                       |  | 2. DATE AND HOUR OF DEATH                                                                                                                                   |  | STATE OF MARYLAND - DEPT                                                                                                                                                                                                                                                                              |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                       |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY                                  |  | 5. CITY OR TOWN                                                                                                                                             |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                         |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |  | E. STREET AND NUMBER                                                                                                                         |  | F. CITY OR TOWN                                                                                                                                             |  | G. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                         |  |
| BALTO. CITY HOSPITAL                                                                                         |  | 8255 LONGPOINT RD. 21222                                                                                                                     |  | DUNDALK                                                                                                                                                     |  | 5300                                                                                                                                                                                                                                                                                                  |  |
| 5. SEX                                                                                                       |  | 6. RACE                                                                                                                                      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                      |  |
| MALE                                                                                                         |  | CAUCASIAN                                                                                                                                    |  | 14 JUNE 94                                                                                                                                                  |  | 9. AGE (In years last birthday) 78                                                                                                                                                                                                                                                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                            |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                          |  |
| AUTO SALESMAN                                                                                                |  | RETIRED                                                                                                                                      |  | NORTH CAROLINA                                                                                                                                              |  | U. S. A.                                                                                                                                                                                                                                                                                              |  |
| 13. FATHER'S NAME                                                                                            |  | 14. MOTHER'S MAIDEN NAME                                                                                                                     |  | 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)                                                 |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                               |  |
| CLARENCE SAWYER                                                                                              |  | CARRIE HOLMES                                                                                                                                |  | YES                                                                                                                                                         |  | 299-05-3249                                                                                                                                                                                                                                                                                           |  |
| 17. INFORMANT (NIFE)                                                                                         |  | ADDRESS                                                                                                                                      |  | 18. CAUSE OF DEATH                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                          |  |
| Mrs. Mildred Sawyer - 8255 Longpoint Rd                                                                      |  | Cormay Occlusion                                                                                                                             |  | Hypertension + A-S-C-V Disease                                                                                                                              |  | 12 yrs                                                                                                                                                                                                                                                                                                |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                           |  | (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  | ANTECEDENT CAUSES                                                                                                                                           |  | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                             |  |
| 410101                                                                                                       |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                   |  |
| II                                                                                                           |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).             |  | 19A. DATE OF OPERATION                                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                      |  |
| 19A. DATE OF OPERATION                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  | 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                         |  |
| NONE                                                                                                         |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                       |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  | 22. I certify that (I) (this hospital) attended the deceased from Oct 4 1960 to Apr 8 1972, that (I) lost saw the deceased alive on August 11 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |
| 23A. SIGNATURE                                                                                               |  | 23B. DATE SIGNED                                                                                                                             |  | 23C. PHYSICIAN'S NAME (Type)                                                                                                                                |  | 23D. ADDRESS                                                                                                                                                                                                                                                                                          |  |
| M. B. DAVIS, MD                                                                                              |  | SEPT 9-1972                                                                                                                                  |  | M. B. DAVIS, MD                                                                                                                                             |  | 6800 MORNINGTON RD. 21222                                                                                                                                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                     |  | 24B. DATE                                                                                                                                    |  | 24C. NAME OF CEMETERY or CREMATORY                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                         |  |
| Burial                                                                                                       |  | Sept 12/72                                                                                                                                   |  | Garden of Faith                                                                                                                                             |  | Baltimore Co. MD                                                                                                                                                                                                                                                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                              |  | 25B. NAME OF REGISTRAR                                                                                                                       |  | 25C. FUNERAL DIRECTOR                                                                                                                                       |  | ADDRESS                                                                                                                                                                                                                                                                                               |  |
| SEP 13 1972                                                                                                  |  | [Signature]                                                                                                                                  |  | [Signature]                                                                                                                                                 |  | [Signature]                                                                                                                                                                                                                                                                                           |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                 |         |                                                                                          |                  | REG. NO.                                                                 | 72 08763                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| R-253                                                                                                                                                                                                                                                                                            |         | 72 08763                                                                                 |                  | CERTIFICATE OF DEATH                                                     |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                           |         | 2. DATE AND HOUR OF DEATH                                                                |                  |                                                                          |                                                        |
| DAVID ROSENTHAL                                                                                                                                                                                                                                                                                  |         | 9.9.72 9 P M.                                                                            |                  |                                                                          |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                           |         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |                  |                                                                          |                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                     |         | A. STATE B. COUNTY                                                                       |                  |                                                                          |                                                        |
| MERCY HOSPITAL                                                                                                                                                                                                                                                                                   |         | MARYLAND AA 5200                                                                         |                  |                                                                          |                                                        |
| 37                                                                                                                                                                                                                                                                                               |         | C. CITY OR TOWN                                                                          |                  | D. INSIDE CITY LIMITS?                                                   |                                                        |
|                                                                                                                                                                                                                                                                                                  |         | BALTIMORE                                                                                |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                        |
|                                                                                                                                                                                                                                                                                                  |         | E. STREET AND NUMBER                                                                     |                  |                                                                          |                                                        |
|                                                                                                                                                                                                                                                                                                  |         | 195 MEADOW ROAD                                                                          |                  |                                                                          |                                                        |
| 5. SEX                                                                                                                                                                                                                                                                                           | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                          | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| m                                                                                                                                                                                                                                                                                                | w       | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 7.9.01           | 71                                                                       |                                                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                      |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                  | 11. BIRTHPLACE (State or foreign country)                                |                                                        |
| Retired Chemist                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  | Maryland                                                                 |                                                        |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                |         | 14. MOTHER'S MAIDEN NAME                                                                 |                  | 12. CITIZEN OF WHAT COUNTRY?                                             |                                                        |
| MORRIS ROSENTHAL                                                                                                                                                                                                                                                                                 |         | ESTHER                                                                                   |                  | USA                                                                      |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                         |         | 16. SOCIAL SECURITY NO.                                                                  |                  | 17. INFORMANT ADDRESS                                                    |                                                        |
| NO NONE                                                                                                                                                                                                                                                                                          |         | 168-07-6550                                                                              |                  | Helen C. Rosenthal 195 Meadow Rd. 21225                                  |                                                        |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                               |         | CAUSE OF DEATH                                                                           |                  |                                                                          |                                                        |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                     |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |                                                                          |                                                        |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                |         | BILATERAL BRONCHOPNEUMONIA & LUNG ABSCESS                                                |                  |                                                                          |                                                        |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.                                                                                                                                                                                        |         | (B) CACHEXIA DUE TO, OR AS A CONSEQUENCE OF:                                             |                  |                                                                          |                                                        |
|                                                                                                                                                                                                                                                                                                  |         | (C)                                                                                      |                  |                                                                          |                                                        |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                              |         |                                                                                          |                  |                                                                          |                                                        |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                           |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                |                                                        |
| 2                                                                                                                                                                                                                                                                                                |         |                                                                                          |                  | Yes.                                                                     |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)                                                                                                                                                                                                            |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location) |                                                        |
|                                                                                                                                                                                                                                                                                                  |         |                                                                                          |                  |                                                                          |                                                        |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                    |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                               |                                                        |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                      |         | While At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>        |                  |                                                                          |                                                        |
| 22. I certify that (this hospital) attended the deceased from 8.23.19 72 to 9.10.19 72, that (we) lost saw the deceased alive on 9.10.19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                          |                                                        |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                   |         | 23B. DATE SIGNED                                                                         |                  |                                                                          |                                                        |
| Tolhu ONE MD                                                                                                                                                                                                                                                                                     |         | 9/10/72                                                                                  |                  |                                                                          |                                                        |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                     |         | 23D. ADDRESS                                                                             |                  |                                                                          |                                                        |
| Tolhu ONE MD                                                                                                                                                                                                                                                                                     |         | Mercy Hospital, Baltimore                                                                |                  |                                                                          |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                         |         | 24B. DATE                                                                                |                  | 24C. NAME of CEMETERY or CREMATORY                                       |                                                        |
| Burial                                                                                                                                                                                                                                                                                           |         | 9/12/72                                                                                  |                  | Glen Haven                                                               |                                                        |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                  |         | 25B. NAME OF REGISTRAR                                                                   |                  | 25C. FUNERAL DIRECTOR ADDRESS                                            |                                                        |
| SEP 13 1972                                                                                                                                                                                                                                                                                      |         | Sidney Whorton                                                                           |                  | Mc Cully 237 Patapsco Ave. 21225                                         |                                                        |



1

H-300 72 08764 STATE OF MARYLAND BALTIMORE CITY HEALTH DEPARTMENT 72 08764

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                  |                                                                  |                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>FRANCIS HOOD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input checked="" type="checkbox"/> <b>September 9, 1972</b>      |                                                                  | Hour<br>M.                                                                            |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>SOUTH BALTO. GENERAL HOSPITAL (DOA)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>September 9, 1972</b>                                                                            |                                                                  | Hour<br>M.<br><b>3:41 P.</b>                                                          |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2505</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                  |                                                                  |                                                                                       |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | C. CITY OR TOWN<br><b>Baltimore</b>                                                   |
| 9. DATE OF BIRTH<br><b>12/24/18</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 10. AGE (In years last birthday)<br><b>53</b>                                                                                                    | E. STREET AND NUMBER<br><b>4115 Rondo Ct.</b>                    |                                                                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       | 13. FATHER'S NAME<br><b>Henry A. Hood</b>                        |                                                                                       |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Disabled Veteran</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                |                                                                  | 15. MOTHER'S MAIDEN NAME<br><b>Mattie Mathias</b>                                     |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 17. SOCIAL SECURITY NO.<br><b>NONE</b>                                                                                                           |                                                                  | 18. INFORMANT<br><b>Mrs. Edith C. Hood</b>                                            |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Parkinson's Disease</b>                                                                                                                                                                                                                                                                                               |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                     |                                                                  |                                                                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  |                                                                  |                                                                                       |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                                  | 21. AUTOPSY? (Yes or No)<br><b>NO</b>                                                 |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |                                                                  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |
| 22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                        |                                                                  | 22F. HOW DID INJURY OCCUR?                                                            |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b> M.D.<br>EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>9/10/72</b> |                         |                                                                                                                                                  |                                                                  |                                                                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 24B. DATE<br><b>9/13/72</b>                                                                                                                      | 24C. NAME OF CEMETERY or CREMATORY<br><b>Gettysburg National</b> |                                                                                       |
| 24D. LOCATION (City, town, or county) (State)<br><b>Gettysburg, Pa.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  |                                                                  |                                                                                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 12 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 25B. NAME OF REGISTRAR<br><b>Aisley W. K. ...</b>                                                                                                |                                                                  | 25C. FUNERAL DIRECTOR<br><b>Mc Cully</b><br>ADDRESS<br><b>237 Patapsco Ave. 21225</b> |

VS 134 REV. 1/7/68

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-374301)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [Illegible]

RE: NEW YORK TELETYPE TO BUREAU, 1/11/68  
AND BUREAU TELETYPE TO NEW YORK, 1/11/68

FOR INFORMATION OF THE BUREAU, THE FOLLOWING  
IS A SUMMARY OF THE INFORMATION RECEIVED  
FROM THE NEW YORK OFFICE:

On 1/10/68, [Illegible] advised that  
[Illegible] had been contacted by [Illegible]  
who stated that [Illegible] was planning to  
travel to New York City on 1/11/68.

The New York Office is currently conducting  
an investigation into the activities of [Illegible]  
and is attempting to identify all individuals  
who may be involved in the same.

It is requested that the Bureau be kept  
advised of any further information received  
regarding this matter.

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

Enclosure  
100-100000-1000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                                                           |                                                                                                                                                             | REG. NO. <u>911192172</u>                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <u>JACKSON JOHN</u>                                                                                                                                                                                                                                                                  |                                                                                                        | 2. DATE AND HOUR OF DEATH<br><u>9.8.72 3.45pm.</u>                                                                                                                                        |                                                                                                                                                             |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                      |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>605</u>                                                    |                                                                                                                                                             |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>CHURCH Home &amp; Hospital</u>                                                                                                                                                                                                                                                   |                                                                                                        | C. CITY OR TOWN<br><u>BALTIMORE</u>                                                                                                                                                       |                                                                                                                                                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                             |                                                                                                        | 6. RACE <u>N</u>                                                                                                                                                                          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12.08.1908</u>                                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>unemployed</u>                                                                                                                                                                                                            |                                                                                                        | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                         | 11. BIRTHPLACE (State or foreign country)<br><u>VERGINIA</u>                                                                                                | 9. AGE (in years last birthday)<br><u>63 yrs.</u>                                             |
| 13. FATHER'S NAME<br><u>Lee Jackson</u>                                                                                                                                                                                                                                                                                     |                                                                                                        | 14. MOTHER'S MAIDEN NAME<br><u>Flora Hegman</u>                                                                                                                                           |                                                                                                                                                             |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) If yes, give war or dates of service                                                                                                                                                                                                                   |                                                                                                        | 16. SOCIAL SECURITY NO.<br><u>218-14-8582</u>                                                                                                                                             | 17. INFORMANT<br><u>RUTH JACKSON (wife)</u> ADDRESS<br><u>226 BRAD ST. 21231 BALD MD</u>                                                                    |                                                                                               |
| 18. <u>518-3 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Acute on chronic Respiratory Failure</u>                                                         |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                              |                                                                                                                                                             |                                                                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.                                                                                                                                                                                              |                                                                                                        | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Chronic Obstructive Lung Disease</u><br>(B) <u>Acute Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                                                                                                             |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                                                           |                                                                                                                                                             |                                                                                               |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>None</u>                                        | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                 | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                       | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                  |                                                                                                                                                             |                                                                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                |                                                                                                                                                             |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8.18.72</u> 19 to <u>9.8.72</u> 19 that (I) (we) last saw the deceased alive on <u>9.8.72</u> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                                                           |                                                                                                                                                             |                                                                                               |
| 23A. SIGNATURE<br><u>[Signature]</u> MD                                                                                                                                                                                                                                                                                     |                                                                                                        | 23B. DATE SIGNED<br><u>9.8.72</u>                                                                                                                                                         |                                                                                                                                                             | 23C. PHYSICIAN'S NAME (Type)<br><u>FIR0201</u>                                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                    |                                                                                                        | 24B. DATE<br><u>9.12.72</u>                                                                                                                                                               | 24C. NAME of CEMETERY or CREMATORY<br><u>St. James Cemetery</u>                                                                                             | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore Md.</u>                         |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 13 1972</u>                                                                                                                                                                                                                                                                       |                                                                                                        | 25B. NAME OF REGISTRAR<br><u>[Signature]</u>                                                                                                                                              |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><u>[Signature]</u> ADDRESS<br><u>[Address]</u>                       |



226 BEALE CT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                              |                                                   |                                                                                                                                                             |                                                                          | REG. NO. <b>72 08766</b><br><b>STATE OF MARYLAND</b>                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| BIRTH NO. <b>P.360</b>                                                                                                                                                                                                                                                                                                                |                                                   | 72 08766                                                                                                                                                    |                                                                          |                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>HERMAN C. POWDER</b>                                                                                                                                                                                                                                                                        |                                                   | 2. DATE AND HOUR OF DEATH<br><b>9/10/72</b> <b>1 48 A M.</b>                                                                                                |                                                                          |                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                |                                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b>                   |                                                                          |                                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33 THE JOHNS HOPKINS HOSPITAL<br/>BALTIMORE, MD 21205</b>                                                                                                                                                             |                                                   | C. CITY OR TOWN <b>MT AIRY</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |                                                                          |                                                                             |
|                                                                                                                                                                                                                                                                                                                                       |                                                   | E. STREET AND NUMBER <b>RT 2 BOX 105</b>                                                                                                                    |                                                                          |                                                                             |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><b>WHITE</b>                           | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>04-16-02</b>                                      | 9. AGE (In years last birthday)<br><b>70</b>                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>                                                                                                                                                                                                                        |                                                   | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                          | 11. BIRTHPLACE (State or foreign country)<br><b>Carroll Co., Md.</b>        |
| 13. FATHER'S NAME<br><b>WILLIAM POWDER</b>                                                                                                                                                                                                                                                                                            |                                                   | 14. MOTHER'S MAIDEN NAME<br><b>MARTHA WAMPER</b>                                                                                                            |                                                                          |                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                 |                                                   | 16. SOCIAL SECURITY NO.<br><b>215-03-7430</b>                                                                                                               |                                                                          | 17. INFORMANT<br><b>Mrs. Macy I. Powder</b>                                 |
|                                                                                                                                                                                                                                                                                                                                       |                                                   |                                                                                                                                                             |                                                                          | ADDRESS<br><b>Same As #4.</b>                                               |
| 18. <b>412.41</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiac arrhythmia</b>                                                                                        |                                                   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                         |                                                                          |                                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                        |                                                   | (B) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                       |                                                                          |                                                                             |
| (C) _____                                                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                             |                                                                          |                                                                             |
| II                                                                                                                                                                                                                                                                                                                                    |                                                   |                                                                                                                                                             |                                                                          |                                                                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                      |                                                   |                                                                                                                                                             |                                                                          |                                                                             |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                    |                                                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                          | 20A. AUTOPSY (Yes or No)<br><b>NO</b>                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                 |                                                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                          | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                             |                                                   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                          | 21F. HOW DID INJURY OCCUR?                                                  |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>9/11/72</b> to <b>9/10/72</b> that (I) <u>(we)</u> last saw the deceased alive on <b>9/10/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                   |                                                                                                                                                             |                                                                          |                                                                             |
| 23A. SIGNATURE<br><b>Stephen V. Neville M.D.</b>                                                                                                                                                                                                                                                                                      |                                                   | 23B. DATE SIGNED<br><b>9/10/72</b>                                                                                                                          |                                                                          | 23C. PHYSICIAN NAME (Type)<br><b>STEPHEN V. NEVILLE M.D.</b>                |
|                                                                                                                                                                                                                                                                                                                                       |                                                   | 23D. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                           |                                                                          |                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                             | 24B. DATE<br><b>9/13/1972</b>                     | 24C. NAME of CEMETERY or CREMATORY<br><b>Evergreen Memorial Gardens</b>                                                                                     | 24D. LOCATION (City, town, or county) (State)<br><b>Carroll Co., Md.</b> |                                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                 | 25B. NAME OF REGISTRAR<br><b>Silvia H. Hinton</b> | 25C. FUNERAL DIRECTOR ADDRESS<br><b>C.M. Waltz, Box 326, Sykesville, Md.</b>                                                                                |                                                                          |                                                                             |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                              |  | REG. NO. 72 08707                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|
| BIRTH NO. <u>C-230</u>                                                                                                                                                                                                                                                                                                                    |  | 1. NAME OF DECEASED<br>(Type or Print) <u>COST, HORACE FREDERICK COST, SR.</u>                                                                                                                               |  |                                                                            |
| 2. DATE AND HOUR OF DEATH<br><u>SEPTEMBER 6, 1972 1:00 A</u>                                                                                                                                                                                                                                                                              |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>ST AGNES HOSPITAL</u><br><u>40</u> |  |                                                                            |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>2582</u>                                                                                                                                                                                                |  | 5. SEX <u>MALE</u> 6. RACE <u>CAUCASIAN</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         |  |                                                                            |
| C. CITY OR TOWN <u>BALTIMORE</u>                                                                                                                                                                                                                                                                                                          |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                   |  |                                                                            |
| E. STREET AND NUMBER<br><u>1005 DESOTO ROAD 21223</u>                                                                                                                                                                                                                                                                                     |  | 8. DATE OF BIRTH <u>05-26-91</u> 9. AGE (In years last birthday) <u>81</u>                                                                                                                                   |  |                                                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>SALESMAN</u>                                                                                                                                                                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                            |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>               |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                                                                                                                                                                |  | 13. FATHER'S NAME<br><u>GEORGE J COST</u>                                                                                                                                                                    |  |                                                                            |
| 14. MOTHER'S MAIDEN NAME<br><u>Helen T. Spalding</u>                                                                                                                                                                                                                                                                                      |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>YES WWI</u>                                                                                   |  |                                                                            |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                   |  | 17. INFORMANT<br><u>RECORD'S BALTIMORE MD 21229</u><br><u>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</u>                                                                                                      |  |                                                                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death)<br><u>① fibrinoid pericarditis</u><br><u>② pulmonary embolism, rt lung</u>                                                              |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>③ Subcapital Fr of rt hip.</u>                                                                                                   |  |                                                                            |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, leading to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u>                                                                                                                                                                                               |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A):<br><u>3 days</u>                                                            |  |                                                                            |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                    |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                             |  | 20A. AUTOPSY? (Yes or No)<br><u>yes</u>                                    |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                      |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><u>Medical examiner Notified</u>                                                                                    |  |                                                                            |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>Home</u>                                                                                                                                                                                                                                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><u>Home city</u>                                                                                                                 |  |                                                                            |
| 21D. TIME OF INJURY (APPROX.)<br><u>Sep 3 1972 PM</u>                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                                                                            |  | 21F. HOW DID INJURY OCCUR?<br><u>Subject fell on steps</u>                 |
| 22. I certify that (X) (this hospital) attended the deceased from <u>SEPTEMBER 4, 1972</u> to <u>SEPTEMBER 6, 1972</u> , that (X) (we) lost the deceased on <u>SEPTEMBER 6, 1972</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. |  |                                                                                                                                                                                                              |  |                                                                            |
| 23A. SIGNATURE<br><u>Tse-shiung Wu, M.D.</u>                                                                                                                                                                                                                                                                                              |  | 23B. DATE SIGNED<br><u>9/6/72</u>                                                                                                                                                                            |  | 23C. PHYSICIAN'S NAME (Type)<br><u>Tse-shiung Wu, M.D.</u>                 |
| 23D. ADDRESS<br><u>BALTIMORE MD 21229</u><br><u>STAGNES HOSPITAL WILKENS &amp; CATON AVE</u>                                                                                                                                                                                                                                              |  | 24. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                     |  |                                                                            |
| 24B. DATE<br><u>9-11-1972</u>                                                                                                                                                                                                                                                                                                             |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Woodlawn Cemetery</u>                                                                                                                                               |  | 24D. LOCATION (City, town, or county) (State)<br><u>Woodlawn, Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 13 1972</u>                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br><u>Audrey Houston</u>                                                                                                                                                              |  | 25C. FUNERAL DIRECTOR<br><u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> |

POST, WHITE PROSECUTION

SEPTEMBER 6, 1972

ST AGNES HOSPITAL

BALTIMORE

1000 DODGE ROAD

02-26-71

71

XX

WIFE CAUCASIAN

MARYLAND

420

SALESMAN

GEORGE COSY

WIFE

ST AGNES HOSPITAL

RECORDS BALTIMORE

XX

SEPTEMBER 6, 72

XX

XXXX

BALTIMORE NO 21220  
STAGNES HOSPITAL WILKINS & CATON AVE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                    |  |                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                             |                                                                                    |                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                |  |                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                             |                                                                                    |                                                                           |  |
| REG. NO. 72 08768                                                                                                                                                                                                                                                                                                   |  |                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                             |                                                                                    |                                                                           |  |
| W-256                                                                                                                                                                                                                                                                                                               |  | BIRTH NO.            |  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |  |                                                                                       |  | 2. DATE AND HOUR OF DEATH                                                   |                                                                                    |                                                                           |  |
|                                                                                                                                                                                                                                                                                                                     |  |                      |  | 72 08768<br>Joseph Carlson Wagner                                                                                                                           |  |                                                                                       |  | Sept. 10, 1972 8:37 A.M.                                                    |                                                                                    |                                                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                              |  |                      |  |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |                                                                             |                                                                                    |                                                                           |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>US Public Health Service Hospital<br>3100 Wyman Parkway                                                                                                                                                                                                                     |  |                      |  |                                                                                                                                                             |  | A. STATE<br>Md. BALTO 5300                                                            |  |                                                                             |                                                                                    |                                                                           |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                |  |                      |  |                                                                                                                                                             |  | C. CITY OR TOWN<br>Timonium                                                           |  |                                                                             | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                           |  |
|                                                                                                                                                                                                                                                                                                                     |  |                      |  |                                                                                                                                                             |  | E. STREET AND NUMBER<br>2312 Foxley Rd.                                               |  |                                                                             |                                                                                    |                                                                           |  |
| 5. SEX<br>M                                                                                                                                                                                                                                                                                                         |  | 6. RACE<br>Caucasian |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>11/22/20                                                          |  | 9. AGE (In years last birthday)<br>51                                       |                                                                                    | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>General Manager                                                                                                                                                                                                      |  |                      |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Ticket Issuing Co.                                                                                                     |  | 11. BIRTHPLACE (State or foreign country)<br>NY                                       |  |                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                |                                                                           |  |
| 13. FATHER'S NAME<br>Joseph Wagner                                                                                                                                                                                                                                                                                  |  |                      |  |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br>Alma Carlson                                              |  |                                                                             |                                                                                    |                                                                           |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes USN 1943-1945                                                                                                                                                                                       |  |                      |  | 16. SOCIAL SECURITY NO.<br>072-14-5236                                                                                                                      |  | 17. INFORMANT ADDRESS<br>Records- US PHS Hospital, Balto, Md.                         |  |                                                                             |                                                                                    |                                                                           |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                  |  |                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                             |                                                                                    |                                                                           |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Bilateral bronchopneumonia                                                                                        |  |                      |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 days                               |  |                                                                             |                                                                                    |                                                                           |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Acute myelocytic leukemia                                                                                                                                                         |  |                      |  |                                                                                                                                                             |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>2 yrs.                                         |  |                                                                             |                                                                                    |                                                                           |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                 |  |                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                             |                                                                                    |                                                                           |  |
| II                                                                                                                                                                                                                                                                                                                  |  |                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                             |                                                                                    |                                                                           |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Acute pulmonary edema                                                                                                                                                           |  |                      |  |                                                                                                                                                             |  | Terminal                                                                              |  |                                                                             |                                                                                    |                                                                           |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |  |                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br>yes                                                      |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>yes |                                                                                    |                                                                           |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                               |  |                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |                                                                             |                                                                                    |                                                                           |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                           |  |                      |  | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                            |  |                                                                             |                                                                                    |                                                                           |  |
| 22. I certify that (I) (this hospital) attended the deceased from June 6 1972 to Sept. 10 1972, that (I) (we) last saw the deceased alive on Sept. 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                      |  |                                                                                                                                                             |  |                                                                                       |  |                                                                             |                                                                                    |                                                                           |  |
| 23A. SIGNATURE<br>Maria de Moraes Ruehsen                                                                                                                                                                                                                                                                           |  |                      |  |                                                                                                                                                             |  |                                                                                       |  | 23B. DATE SIGNED<br>9/11/72                                                 |                                                                                    | 23C. PHYSICIAN'S NAME (Type)<br>Maria De Moraes Ruehsen, MD               |  |
| 23D. ADDRESS<br>US PHS Hospital, Balto, Md.                                                                                                                                                                                                                                                                         |  |                      |  |                                                                                                                                                             |  |                                                                                       |  | 23E. DEGREE                                                                 |                                                                                    | 23F. DEGREE                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                  |  |                      |  | 24B. DATE<br>9-13-72                                                                                                                                        |  | 24C. NAME OF CEMETERY or CREMATORY<br>Dulaney Valley Mem. Gardens                     |  |                                                                             |                                                                                    | 24D. LOCATION (City, town, or county) (State)<br>Timonium, Maryland 21093 |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                      |  |                      |  | 25B. NAME OF REGISTRAR<br>Sidney [Signature]                                                                                                                |  | 25C. FUNERAL DIRECTOR ADDRESS<br>Wm. Cook-Brooks Towson Towson, Md. 21204             |  |                                                                             |                                                                                    |                                                                           |  |





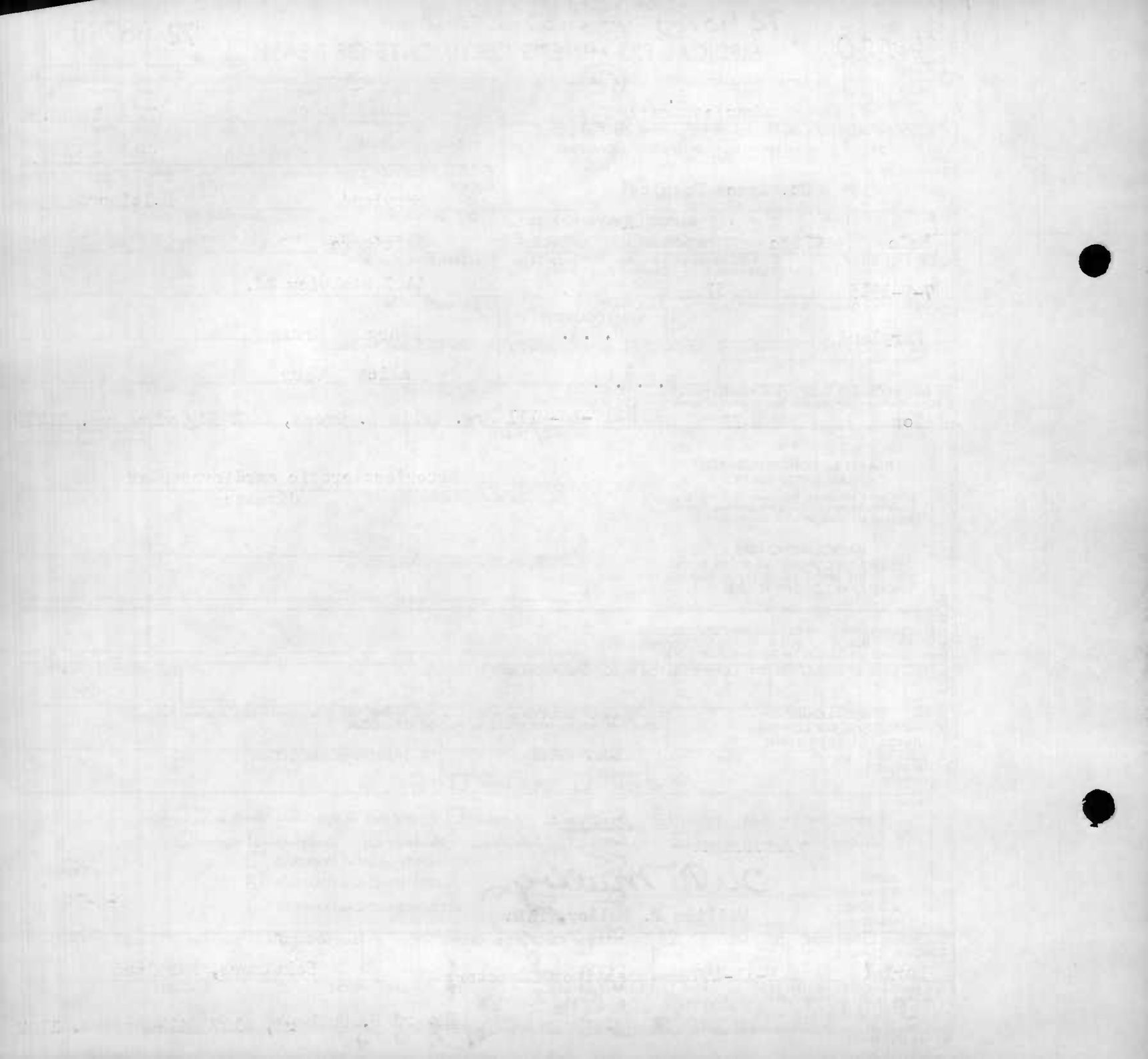
G-620

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Charles Gress</b>                                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>9 8 72 2:18A. M.</b>                       |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                          |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>9 8 72 2:18 A.M.</b>                                                                                                |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br><b>White</b>                                                                                                                                                  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                      |  |
| 9. DATE OF BIRTH<br><b>7-9-1915</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 10. AGE (in years lost birthday)<br><b>57</b>                                                                                                                            |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                            |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br><b>Alice Carr</b>                                                                                                                            |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                |  | 17. SOCIAL SECURITY NO.<br><b>217-14-0171</b>                                                                                                                            |  |
| 18. INFORMANT<br><b>Mrs. Celia L. Gress</b>                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS<br><b>4407 Highview Ave. 21229</b>                                                                                                                               |  |
| 19. CAUSE OF DEATH<br><b>412.4</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular</b>                                                                                                                                                                              |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>disease</b>                                                                                                       |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                       |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                      |  |
| (C)                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                          |  |
| 20A. DATE OF OPERATION<br><b>9-11-1972</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                 |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                 |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                            |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                   |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                           |  | 22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                 |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 21. AUTOPSY? (Yes or No)<br><b>No</b>                                                                                                                                    |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>William P. Mulloy, M.D.</b>                                                                                                                                                                                                                                                                                                                                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br><b>9-8-72</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br><b>9-11-1972</b>                                                                                                                                            |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore Cemetery</b>                                                                                                                                                                                                                                                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br><b>Howard H. Hubbard</b>                                                                                                                       |  |
| 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard</b>                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><b>4107 Wilkens Ave. 21229</b>                                                                                                                                |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                         |  |                                                                                          |  |                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| C-636 72 08770                                                                                                                                                                                                                                                                                          |  | BALTIMORE CITY HEALTH DEPARTMENT                                                         |  | 72 08770                                                                 |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                               |  | CERTIFICATE OF DEATH                                                                     |  | REG. NO.                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                  |  | 2. DATE AND HOUR OF DEATH                                                                |  |                                                                          |  |
| Carter, James Edward                                                                                                                                                                                                                                                                                    |  | 9-9-72 4 20 P.M.                                                                         |  |                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |  |                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                               |  | A. STATE B. COUNTY                                                                       |  |                                                                          |  |
| Boulton Hill Nsg. & Conv. Home                                                                                                                                                                                                                                                                          |  | Md. Balt                                                                                 |  | 2710                                                                     |  |
| 5. SEX 6. RACE                                                                                                                                                                                                                                                                                          |  | C. CITY OR TOWN                                                                          |  | D. INSIDE CITY LIMITS?                                                   |  |
| M N                                                                                                                                                                                                                                                                                                     |  | Balt                                                                                     |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                |  | E. STREET AND NUMBER                                                                     |  |                                                                          |  |
|                                                                                                                                                                                                                                                                                                         |  | The Alameda                                                                              |  | 21218                                                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                             |  | 8. DATE OF BIRTH                                                                         |  | 9. AGE (In years last birthday)                                          |  |
| Janitor                                                                                                                                                                                                                                                                                                 |  | 3-1-92                                                                                   |  | 80                                                                       |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                       |  | 11. BIRTHPLACE (State or foreign country)                                                |  | 12. CITIZEN OF WHAT COUNTRY?                                             |  |
|                                                                                                                                                                                                                                                                                                         |  | King & Queen Co. Virginia                                                                |  | U.S.A.                                                                   |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                       |  | 14. MOTHER'S MAIDEN NAME                                                                 |  |                                                                          |  |
| Edward Carter                                                                                                                                                                                                                                                                                           |  | UNKNOWN                                                                                  |  |                                                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                |  | 16. SOCIAL SECURITY NO.                                                                  |  | 17. INFORMANT ADDRESS                                                    |  |
| UNKNOWN                                                                                                                                                                                                                                                                                                 |  | 216-12-2457                                                                              |  | Ada Carter ↑ Same as above                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                      |  | CAUSE OF DEATH                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                            |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  | 2 weeks                                                                  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                       |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  | years                                                                    |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                               |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  | years                                                                    |  |
| II                                                                                                                                                                                                                                                                                                      |  |                                                                                          |  |                                                                          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                        |  |                                                                                          |  |                                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                |  |
|                                                                                                                                                                                                                                                                                                         |  |                                                                                          |  |                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|                                                                                                                                                                                                                                                                                                         |  |                                                                                          |  |                                                                          |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                         |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                               |  |
| (APPROX.)                                                                                                                                                                                                                                                                                               |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8/17 1972 to 9/9 1972 that (I) (we) last saw the deceased alive on 9/11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                          |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                          |  | 23B. DATE SIGNED                                                                         |  |                                                                          |  |
| ALAN H. MARCH MD                                                                                                                                                                                                                                                                                        |  | 9/11/72                                                                                  |  |                                                                          |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                            |  | 23D. ADDRESS                                                                             |  |                                                                          |  |
| ALAN H. MARCH MD                                                                                                                                                                                                                                                                                        |  | 216 Pearl St. Balt Md                                                                    |  |                                                                          |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)                                                                                                                                                                                                                                                                 |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| Burial                                                                                                                                                                                                                                                                                                  |  | 9-13-72                                                                                  |  | Mt. Auburn Cem.                                                          |  |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                           |  | 24E. FUNERAL DIRECTOR                                                                    |  | 24F. ADDRESS                                                             |  |
| Baltimore Md                                                                                                                                                                                                                                                                                            |  | Mortimer D. Yett F.H.                                                                    |  | 1701-LAURENS ST                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                    |  |
| SEP 13 1972                                                                                                                                                                                                                                                                                             |  | Mortimer D. Yett                                                                         |  | F.H.                                                                     |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                          |  |                                                                                       |  | 72 08771                                                                                                                                                    |  |                                                |  | 72 08771                                                                                                                                                 |  |                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                 |  |                                                                                       |  | 72 08771                                                                                                                                                    |  |                                                |  | 72 08771                                                                                                                                                 |  |                                                                                                         |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                    |  |                                                                                       |  | 2. DATE AND HOUR OF DEATH                                                                                                                                   |  |                                                |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                   |  |                                                                                                         |  |
| VIOLA JUBILEE                                                                                             |  |                                                                                       |  | September 8, 1972                                                                                                                                           |  |                                                |  | Lutheran Hospital                                                                                                                                        |  |                                                                                                         |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                      |  |                                                                                       |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |  |                                                |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)                                                                     |  |                                                                                                         |  |
| 46 Lutheran Hospital                                                                                      |  |                                                                                       |  | A. STATE<br>Maryland                                                                                                                                        |  |                                                |  | B. COUNTY<br>807                                                                                                                                         |  |                                                                                                         |  |
| C. CITY OR TOWN                                                                                           |  |                                                                                       |  | D. INSIDE CITY LIMITS?                                                                                                                                      |  |                                                |  | E. STREET AND NUMBER                                                                                                                                     |  |                                                                                                         |  |
| Baltimore                                                                                                 |  |                                                                                       |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  |                                                |  | 1745 Federal Street                                                                                                                                      |  |                                                                                                         |  |
| 5. SEX<br>F                                                                                               |  | 6. RACE<br>B                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>6/25/15                    |  | 9. AGE (in years last birthday)<br>57                                                                                                                    |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife |  |
| 11. BIRTHPLACE (State or foreign country)<br>Fairfield N.C.                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                |  | 13. FATHER'S NAME<br>George Woods                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br>Mary Woods         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>not                                          |  | 16. SOCIAL SECURITY NO.                                                                                 |  |
| 17. INFORMANT<br>Carlton Jubilee (Husband)                                                                |  | 18. 4/10/91                                                                           |  | CAUSE OF DEATH                                                                                                                                              |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH |  | (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)             |  | ANTECEDENT CAUSES                                                                                       |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Acute Myocardial Infarction |  | (B) Arteriosclerotic Heart Disease                                                                                                                          |  | (C) Congestive Heart Failure                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hours                                                                                                  |  | 10 minutes                                                                                              |  |
| II                                                                                                        |  |                                                                                       |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                            |  |                                                |  | 19A. DATE OF OPERATION                                                                                                                                   |  |                                                                                                         |  |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                       |  | 20A. AUTOPSY? (Yes or No)<br>no                                                                                                                             |  |                                                |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                     |  |                                                                                                         |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                     |  |                                                                                       |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  |                                                |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore-City, give exact location)                                                                                 |  |                                                                                                         |  |
| 21D. TIME OF INJURY (APPROX.)                                                                             |  |                                                                                       |  | 21E. INJURY OCCURRED                                                                                                                                        |  |                                                |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |                                                                                                         |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8 1967 to 9/8 1972                    |  |                                                                                       |  | that (I) (we) lost saw the deceased alive on 9/8 1972                                                                                                       |  |                                                |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                         |  |
| 23A. SIGNATURE<br>Stewart, M.D.                                                                           |  |                                                                                       |  | 23B. DATE SIGNED<br>9/8/72                                                                                                                                  |  |                                                |  | 23C. PHYSICIAN'S NAME (Type)<br>D. W. STEWART, M.D.                                                                                                      |  |                                                                                                         |  |
| 23D. ADDRESS<br>2300 Garrison Blvd. (21216)                                                               |  |                                                                                       |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                          |  |                                                |  | 24B. DATE<br>9-13-72                                                                                                                                     |  |                                                                                                         |  |
| 24C. NAME of CEMETERY or CREMATORY<br>Cedar Hill Cem.                                                     |  |                                                                                       |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.                                                                                              |  |                                                |  | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                           |  |                                                                                                         |  |
| 25B. NAME OF REGISTRAR<br>Mortuary Dyett F. H.                                                            |  |                                                                                       |  | 25C. FUNERAL DIRECTOR<br>1701-1701                                                                                                                          |  |                                                |  | 25D. ADDRESS<br>1701-1701                                                                                                                                |  |                                                                                                         |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                            |  |                                                                                             |                                                                                       | 72 08772                                                                     |                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                        |  |                                                                                             |                                                                                       | REG. NO. STATE OF MARYLAND - DHMH                                            |                                                                                                                                                          |
| BIRTH NO. 72 08772                                                                                                                                                                                                                                                                                                          |  | 1. NAME OF DECEASED (Type or Print) Alex Rose                                               |                                                                                       | 2. DATE AND HOUR OF DEATH 9-8-72 2:15 P.M.                                   |                                                                                                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                      |  |                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                                                              |                                                                                                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                   |  |                                                                                             | A. STATE Maryland                                                                     |                                                                              |                                                                                                                                                          |
| Baltimore City Hospitals<br>4940 Eastern Ave.<br>Baltimore, Md. 21224                                                                                                                                                                                                                                                       |  |                                                                                             | C. CITY OR TOWN Baltimore                                                             |                                                                              | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |
| 5. SEX Male                                                                                                                                                                                                                                                                                                                 |  |                                                                                             | 6. RACE Caucasian                                                                     |                                                                              | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 4-26-11                                                                                                                                                                                                                                                                                                    |  |                                                                                             | 9. AGE (In years last birthday) 61                                                    |                                                                              | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                               |
| 11. BIRTHPLACE (State or foreign country) South Carolina                                                                                                                                                                                                                                                                    |  |                                                                                             | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                   |                                                                              |                                                                                                                                                          |
| 13. FATHER'S NAME William ROSE                                                                                                                                                                                                                                                                                              |  |                                                                                             | 14. MOTHER'S MAIDEN NAME Sarah WILLIAMS                                               |                                                                              |                                                                                                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES OCT 43-APRIL 46                                                                                                                                                                                                |  |                                                                                             | 16. SOCIAL SECURITY NO. 215-05-7834                                                   |                                                                              | 17. INFORMANT 4940 Eastern Ave ADDRESS BCH Records: Baltimore, Md. 21224                                                                                 |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                          |  |                                                                                             |                                                                                       |                                                                              |                                                                                                                                                          |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                 |  |                                                                                             |                                                                                       |                                                                              |                                                                                                                                                          |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)                                                                                                                                                                                               |  |                                                                                             |                                                                                       |                                                                              |                                                                                                                                                          |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                         |  |                                                                                             |                                                                                       |                                                                              |                                                                                                                                                          |
| 19A. DATE OF OPERATION 8-11-72                                                                                                                                                                                                                                                                                              |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACEREBRAL HEMATOMA                     |                                                                                       | 20A. AUTOPSY? (Yes or No) Yes                                                |                                                                                                                                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO                                                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO |                                                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO  |                                                                                                                                                          |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) NO                                                                                                                                                                                                                                                                |  | 21E. INJURY OCCURRED NO                                                                     |                                                                                       | 21F. HOW DID INJURY OCCUR? NO                                                |                                                                                                                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from 16 August 1972 to 8 September 1972 that (I) (we) last saw the deceased alive on 8 September 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                             |                                                                                       |                                                                              |                                                                                                                                                          |
| 23A. SIGNATURE Karl Stecher, M.D.                                                                                                                                                                                                                                                                                           |  |                                                                                             |                                                                                       | 23B. DATE SIGNED 8 Sept. 72                                                  |                                                                                                                                                          |
| 23C. PHYSICIAN'S NAME (Type) Karl Stecher M.D.                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                       | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224 |                                                                                                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL                                                                                                                                                                                                                                                                             |  | 24B. DATE 9-11-72                                                                           |                                                                                       | 24C. NAME OF CEMETERY OR CREMATORY MARYLAND NATIONAL PARK                    |                                                                                                                                                          |
| 24D. LOCATION (City, town, or county) LAUREL, MARYLAND                                                                                                                                                                                                                                                                      |  | 24E. LOCATION (State) MORTON                                                                |                                                                                       | 24F. FUNERAL DIRECTOR MORTON B. DYETT                                        |                                                                                                                                                          |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1972                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR Andrew J. ...                                                        |                                                                                       | 25C. FUNERAL HOME 1701 LAURENS ST.                                           |                                                                                                                                                          |

1

BUR. OF

STATE OF MARYLAND-DEHE  
BALTIMORE CITY HEALTH DEPARTMENT

72 08773  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08773

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>SARAH TUNSTALL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> <b>September 11, 1972</b> M.                                                                                                                                                                                                                                                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>46 LUTHERAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                 |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 11, 1972 3:35 P.M.</b>                                                                                                                                                                                                                                                                                                                         |  |
| 6. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1603</b>                                                                                                                                                                                                                                                                    |  |
| 7. RACE<br><b>Negro</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                           |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                        |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                            |  |
| 9. DATE OF BIRTH<br><b>1-9-1903</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10. AGE (In years last birthday)<br><b>69</b>                                                                                                                                                                                                                                                                                                                                                                 |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                 |  |
| 13. FATHER'S NAME<br><b>JAMES S. PETERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                               |  |
| 15. MOTHER'S MAIDEN NAME<br><b>AGNES HEBRON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                       |  |
| 17. SOCIAL SECURITY NO.<br><b>214-12-4445</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 18. INFORMANT ADDRESS<br><b>MRS. HELEN TUNSTALL 918 N. MOUNT ST,</b>                                                                                                                                                                                                                                                                                                                                          |  |
| 19. <b>43391</b><br>CAUSE OF DEATH<br><b>Cerebral Infarction</b><br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 20A. DATE OF OPERATION<br><b>2-2-72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| ACTUAL SIGNATURE<br><b>Marvin S. Platt, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                                                                                                                                      |  |
| EXAMINER'S NAME (Type)<br><b>Marvin S. Platt, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | DATE SIGNED<br><b>9/12/72</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 24B. DATE<br><b>9-14-72</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>BALTIMORE NATIONAL CEM.</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 25B. NAME OF REGISTRAR<br><b>Sidney H. [Signature]</b>                                                                                                                                                                                                                                                                                                                                                        |  |
| 25C. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT F. H.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br><b>1701 LAURENS ST.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |

7-1-52

MEMORANDUM FOR THE DIRECTOR, FBI

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT:

RE: [illegible]

X

TO: SAC, NEW YORK

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT:

RE: [illegible]

TO: SAC, NEW YORK

100

RECEIVED

TO: SAC, NEW YORK

TO: SAC, NEW YORK

TO: SAC, NEW YORK

TO: SAC, NEW YORK

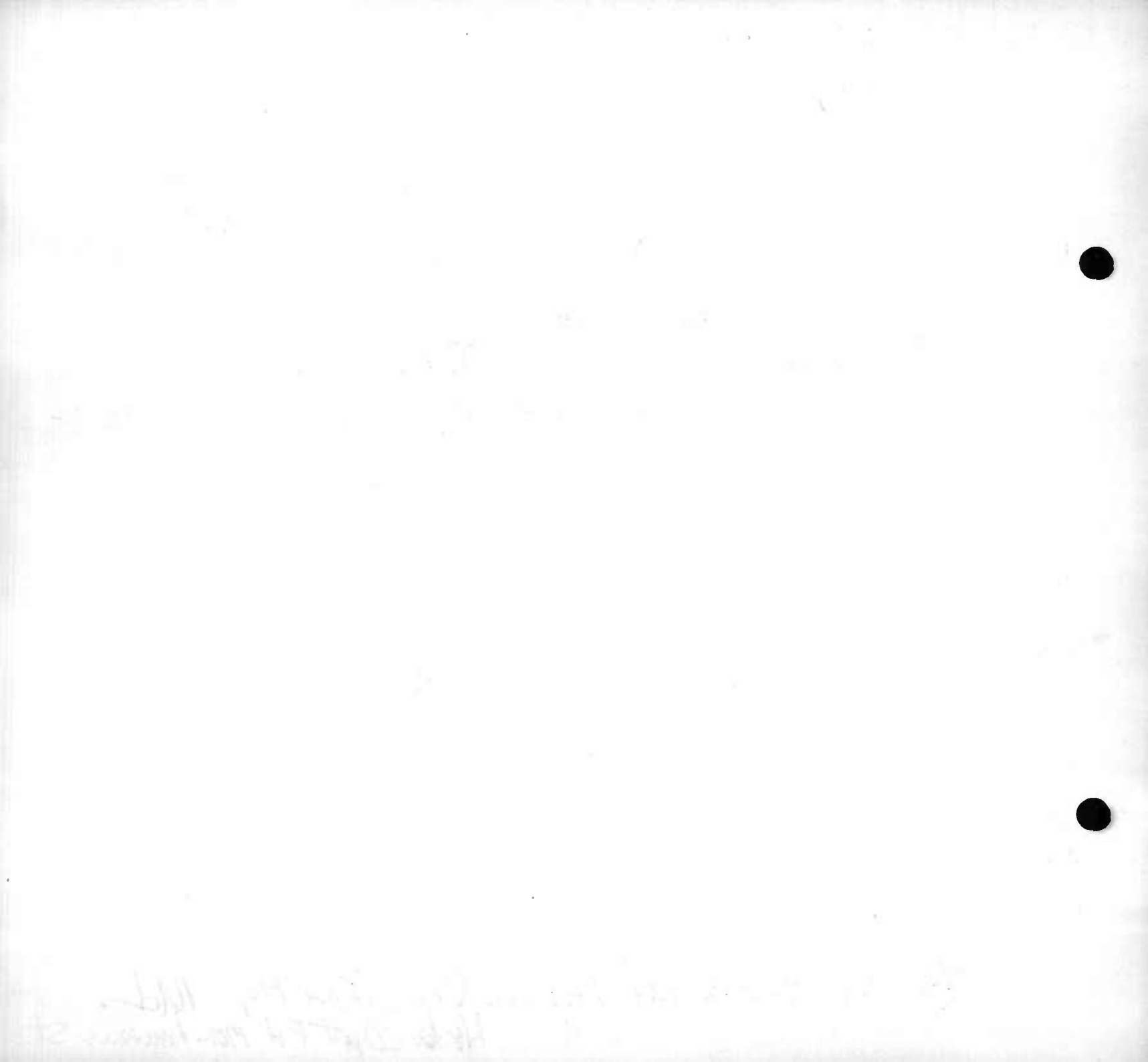
TO: SAC, NEW YORK



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|
| 7-000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 72 08774                                                                                               |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |  | 72 08774                                                                                                                           |  |
| <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | REG. NO. <b>STATE OF MARYLAND-DHMH</b>                                                                                                                      |  |                                                                                                                                    |  |
| BIRTH NO. <b>7-000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | 2. DATE AND HOUR OF DEATH<br><b>9-8-72 1 9-50 P.M.</b>                                                                                                      |  |                                                                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>FREE ROOSEVELT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>Lutheran Hospital 8 Maryland. 46</b>                                                           |  |                                                                                                                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD-</b><br>B. COUNTY <b>1801</b>                       |  | C. CITY OR TOWN <b>BAITIMORE, MD</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. RACE <b>C</b>                                                                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>11-14-18</b><br>9. AGE (In years lost birthday) <b>53</b>                                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Longshore man</b>                                                 |  | 11. BIRTHPLACE (State or foreign country) <b>S. CAR</b>                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>                                                                                          |  |
| 13. FATHER'S NAME <b>Sam Free</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | 14. MOTHER'S MAIDEN NAME <b>Julie Free</b>                                                                                                                  |  |                                                                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO. <b>246-16-4374</b>                                                             |  | 17. INFORMANT <b>WIFE, Lillian</b>                                                                                                                          |  | ADDRESS <b>SAME</b>                                                                                                                |  |
| 18. <b>250.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>diabetes mellitus</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>E. Pelepsy</b> |  |                                                                                                        |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 19A. DATE OF OPERATION <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No) <b>Yes</b>                                                                                                                        |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |                                                                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                                                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8-29-1972</b> to <b>9-8-1972</b> that (I) (we) last saw the deceased alive on <b>9-8-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                             |  |                                                                                                                                    |  |
| 23A. SIGNATURE <b>Shaf Suddi</b> M.D. DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |  | 23B. DATE SIGNED <b>9-8-72</b>                                                                                                     |  |
| 23C. PHYSICIAN'S NAME (Type) <b>J. H. Siddi</b> M.D. DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 23D. ADDRESS <b>Lutheran Hospital</b>                                                                                                                       |  |                                                                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 24B. DATE <b>9-13-72</b>                                                                               |  | 24C. NAME OF CEMETERY OR CREMATORY <b>St. Ambrose Cem.</b>                                                                                                  |  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, MD</b>                                                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR <b>Sidney H. Hinton</b>                                                         |  | 25C. FUNERAL DIRECTOR <b>Robert D. Pratt F.H.</b>                                                                                                           |  | ADDRESS <b>1701-1705 E. 17th St.</b>                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

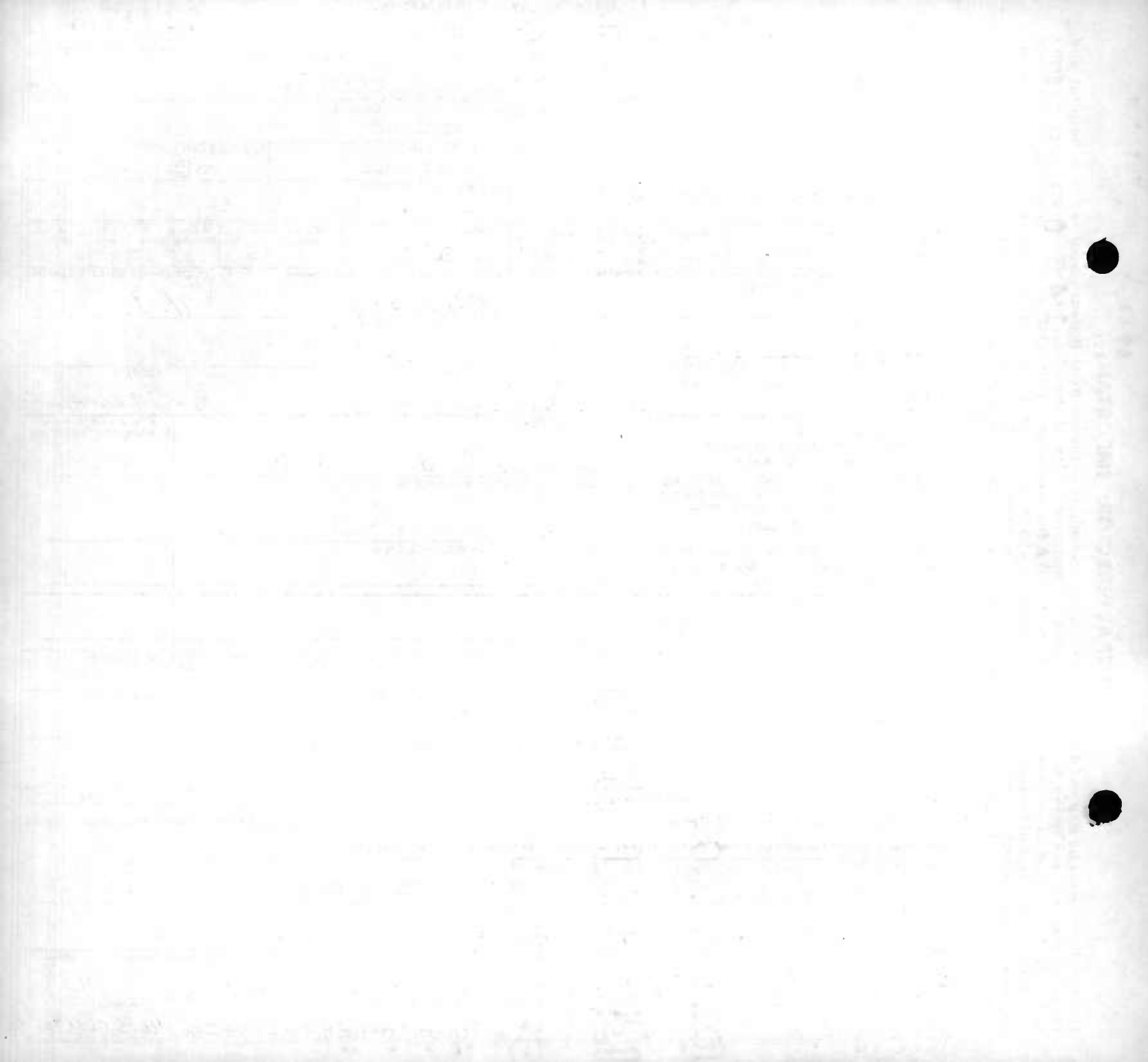
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                           |         |                                                                                          |                  | 72 08775                                                                                                   |                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------|---------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | STATE OF MARYLAND-DEMH                                                                                     |                                 |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                     |         | 2. DATE AND HOUR OF DEATH                                                                |                  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                     |                                 |
| Willie James LeCount                                                                                                                                                                                                                                                                                       |         | 9/10/72 2:00 A.M.                                                                        |                  | FULL NAME OF HOSPITAL OR INSTITUTION<br>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION |                                 |
| 2555 FRANCIS ST BALTIMORE, MD                                                                                                                                                                                                                                                                              |         | Baltimore, Maryland                                                                      |                  | PROVIDENCE HOSPITAL INC.<br>2600 Liberty Heights Ave<br>BALTIMORE, MARYLAND                                |                                 |
| 4. SEX                                                                                                                                                                                                                                                                                                     | 5. RACE | 6. MARRIED                                                                               | 7. NEVER MARRIED | 8. DATE OF BIRTH                                                                                           | 9. AGE (in years last birthday) |
| M                                                                                                                                                                                                                                                                                                          | B       | WIDOWED                                                                                  | DIVORCED         | 09-20-1937                                                                                                 | 34                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                  | 11. BIRTHPLACE (State or foreign country)                                                                  |                                 |
| Allied Moving & Packing Co.                                                                                                                                                                                                                                                                                |         | VAN DRIVER                                                                               |                  | Georgia                                                                                                    |                                 |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                          |         | 14. MOTHER'S MAIDEN NAME                                                                 |                  | 12. CITIZEN OF WHAT COUNTRY                                                                                |                                 |
| Rubin Giles                                                                                                                                                                                                                                                                                                |         | Lucille LeCount                                                                          |                  | 1                                                                                                          |                                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service                                                                                                                                                                                                     |         | 16. SOCIAL SECURITY NO.                                                                  |                  | 17. INFORMANT ADDRESS                                                                                      |                                 |
|                                                                                                                                                                                                                                                                                                            |         | 252-60-2483                                                                              |                  | Betty LeCount 2555 Francis St.                                                                             |                                 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                         |         | CAUSE OF DEATH                                                                           |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                               |                                 |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                               |         | - Malignant hypertension                                                                 |                  | unknown                                                                                                    |                                 |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                          |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |                                                                                                            |                                 |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                  |         | - Hypertensive Encephalopathy                                                            |                  | unknown                                                                                                    |                                 |
|                                                                                                                                                                                                                                                                                                            |         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |                  |                                                                                                            |                                 |
|                                                                                                                                                                                                                                                                                                            |         | - ASCVD & HCVD                                                                           |                  |                                                                                                            |                                 |
|                                                                                                                                                                                                                                                                                                            |         | (C)                                                                                      |                  |                                                                                                            |                                 |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                           |         |                                                                                          |                  |                                                                                                            |                                 |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                     |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                                                  |                                 |
| none                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  |                                                                                                            |                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                      |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                   |                                 |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                          |                  |                                                                                                            |                                 |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                              |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                                                                 |                                 |
| 1 Month 1 Day 1 Year 1 Hour                                                                                                                                                                                                                                                                                |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |                                                                                                            |                                 |
| 22. I certify that (I) (this hospital) attended the deceased from 9-7 19 72 to 9-10 19 72 that (I) (we) last saw the deceased alive on 9-10 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                                                            |                                 |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                             |         | 23B. DATE SIGNED                                                                         |                  | 23C. PHYSICIAN'S NAME (Type)                                                                               |                                 |
| Anna C. Tan, M.D.                                                                                                                                                                                                                                                                                          |         | 9-10-72                                                                                  |                  | ANNA C. TAN, M.D.                                                                                          |                                 |
| 23D. ADDRESS                                                                                                                                                                                                                                                                                               |         | 23E. NAME OF REGISTRAR                                                                   |                  | 23F. FUNERAL DIRECTOR ADDRESS                                                                              |                                 |
| PROVIDENT HOSP. BALTIMORE, MD. 21215                                                                                                                                                                                                                                                                       |         | First A B                                                                                |                  | 1727 N. Monmouth St.                                                                                       |                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                   |         | 24B. DATE                                                                                |                  | 24C. NAME OF CEMETERY or CREMATORY                                                                         |                                 |
| Removal                                                                                                                                                                                                                                                                                                    |         | 9-15-72                                                                                  |                  | First A B                                                                                                  |                                 |
| 24D. LOCATION (City, town, or county)                                                                                                                                                                                                                                                                      |         | 24E. DATE REC'D BY HEALTH DEPT.                                                          |                  | 24F. NAME OF REGISTRAR                                                                                     |                                 |
| Riceboro, Ga.                                                                                                                                                                                                                                                                                              |         | SEP 13 1972                                                                              |                  | Aiden...                                                                                                   |                                 |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                       | REG. NO. <b>72 08776</b>                                                |                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------|
| 72 08776                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                       | STATE OF MARYLAND - <b>DUNN</b>                                         |                                                                            |
| BIRTH NO. <b>K-410</b>                                                                                                                                                                                                                                                                                                                               |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>JOSEPH F. KOLB</b>                                                                                                |                                                                                                                                                                                                                                                                                                                                       | 2. DATE AND HOUR OF DEATH<br><b>9/11/72 10<sup>00</sup> A.M.</b>        |                                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33 The Johns Hopkins Hospital</b>                                                                                                                                      |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>264 S. Duncan Street</b> |                                                                         |                                                                            |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>Cauc.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/2/02</b>                                                                                                                                                                                                                                                                                                    | 9. AGE (In years last birthday) <b>69</b>                               | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                          |                                                                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                |
| 13. FATHER'S NAME<br><b>CHARLES KOOL KOLB</b>                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>ANNA ?</b>                                                                                                                                                                                                                                                                                             |                                                                         |                                                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>213-01-3665</b>                                                                                                                                                                                                                                                                                         |                                                                         | 17. INFORMANT<br><b>Sophia Kolb</b><br>ADDRESS<br><b>264 S. DUNCAN ST.</b> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>410.9 I</b><br><b>Cardiac arrhythmia</b><br><b>Acute myocardial infarction</b><br><b>ASCD</b>                      |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                          |                                                                         |                                                                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                       |                                                                         |                                                                            |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                       | 20A. AUTOPSY (Yes or No)<br><b>Yes</b>                                  |                                                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                       | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) |                                                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                            |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                       | 21F. HOW DID INJURY OCCUR                                               |                                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/6</b> 19 <b>72</b> to <b>9/11</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                       |                                                                         |                                                                            |
| 23A. SIGNATURE<br><b>Stephen V. Neville</b>                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                       | 23B. DATE SIGNED<br><b>9/11/72</b>                                      |                                                                            |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Stephen V. Neville, M.D.</b>                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                       | 23D. ADDRESS<br><b>The Johns Hopkins Hospital</b>                       |                                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                            |                         | 24B. DATE<br><b>9-14-72</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                       | 24C. NAME of CEMETERY or CREMATORY<br><b>HOLY ROSARY CEMETERY</b>       |                                                                            |
| 24D. LOCATION (City, town, or county) (State)<br><b>DUNDALK, Md.</b>                                                                                                                                                                                                                                                                                 |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                       |                                                                                                                                                                                                                                                                                                                                       |                                                                         |                                                                            |
| 25B. NAME OF REGISTRAR<br><b>Andrew W. ...</b>                                                                                                                                                                                                                                                                                                       |                         | 25C. FUNERAL DIRECTOR<br><b>JOHN M. WEBER + SON'S INC. 4015 CHESTER ST.</b>                                                                                 |                                                                                                                                                                                                                                                                                                                                       |                                                                         |                                                                            |



## REG. NO.

BIRTH NO.

VS 151-REV. 1/1/68

7720775

SALE OF LANDS

LANDS OF THE

STATE OF

NEW YORK

IN SENATE

1887

1887

1887

1887

1887



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                  | REG. NO. 72 08778                                                          |                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------|
| K-530 72 08778                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                  | CERTIFICATE OF DEATH                                                       |                                                         |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                  | STATE OF MARYLAND-DEME                                                     |                                                         |
| 1. NAME OF DECEASED<br>(Type or Print)<br>William C Knotts Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>9-8-72 3:45AM                                                                                                                                                                                                                                                                       |                                                                            |                                                         |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Baltimore City Hospitals<br>4940 Eastern Ave., Baltimore, Md. 21224                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |               |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 1616 North Milton Ave. 21213 |                                                                            |                                                         |
| 5. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-23-32                                                                                                                                                                                                                                                                                        | 9. AGE (In years last birthday) 39                                         | 10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |               |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                |                                                                            |                                                         |
| 11. BIRTHPLACE (State or foreign country)<br>Wadesboro, N. C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                           |                                                                            |                                                         |
| 13. FATHER'S NAME<br>William Knotts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br>Ruth Sturdivant                                                                                                                                                                                                                                                                      |                                                                            |                                                         |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br>214 40 8834                                                                                                                                                                                                                                                                           |                                                                            |                                                         |
| 17. INFORMANT<br>Mrs. Hilwert Knotts 2110 Callow Ave. 21217<br>Records: BCH-4940 Eastern Ave. 21224                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               |                                                                                                                                                             | ADDRESS                                                                                                                                                                                                                                                                                                          |                                                                            |                                                         |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>Pneumonia - septisemia<br>(A) IMMEDIATE CAUSE <del>Respiratory arrest</del><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <del>Pneumonia - Coma</del><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <del>multiple abdominal abscesses +</del><br>GI fistulae - following subtotal gastrectomy<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 wk<br>1 wk<br>~ 3 mos |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                         |
| 19A. DATE OF OPERATION<br>06-19-72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>chronic pancreatitis + pseudocyst                                                                       |                                                                                                                                                                                                                                                                                                                  | 20A. AUTOPSY? (Yes or No)<br>NO                                            |                                                         |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                                         |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |               | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                  | 21F. HOW DID INJURY OCCUR?                                                 |                                                         |
| 22. I certify that (I) (this hospital) attended the deceased from May 29 1972 to September 8 1972 that (I) (we) last saw the deceased alive on September 8 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |               |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                         |
| 23A. SIGNATURE<br>Susan Luck MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               |                                                                                                                                                             | 23B. DATE SIGNED<br>9/8/72                                                                                                                                                                                                                                                                                       |                                                                            |                                                         |
| 23C. PHYSICIAN'S NAME (Type)<br>Susan Luck MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |               |                                                                                                                                                             | 23D. ADDRESS<br>4940 Eastern Ave. Baltimore, Md. 21224<br>Baltimore City Hospitals                                                                                                                                                                                                                               |                                                                            |                                                         |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |               | 24B. DATE<br>9-13-1972                                                                                                                                      |                                                                                                                                                                                                                                                                                                                  | 24C. NAME of CEMETERY or CREMATORY<br>Mt. Auburn Cemetery                  |                                                         |
| 24D. LOCATION<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |               | 24E. FUNERAL DIRECTOR<br>1735 Harford Ave. 21213<br>Marshall W. Jones, Jr.                                                                                  |                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                         |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |               | 25B. NAME OF REGISTRAR<br>Sidney Johnson                                                                                                                    |                                                                                                                                                                                                                                                                                                                  | 25C. FUNERAL DIRECTOR<br>1735 Harford Ave. 21213<br>Marshall W. Jones, Jr. |                                                         |

1735 H-1735  
Maryland, 1735

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                       |                                                                                                                                           | REG. NO.                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--|
| 0-520                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 72 08779                                              |                                                                                                                                           | 72 08779                                                 |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                       |                                                                                                                                           |                                                          |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>DOROTHY OWENS</u>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                       | 2. DATE AND HOUR OF DEATH<br><u>9/9/72</u> <u>4:45 A.M.</u>                                                                               |                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                       | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>806</u> |                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>THE JOHNS HOPKINS HOSPITAL</u><br><u>BALTIMORE, MD 21205</u>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                       | C. CITY OR TOWN<br><u>BALTIMORE</u><br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                                          |  |
| 5. SEX<br><u>FEMALE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                       | 6. RACE<br><u>NEGRO</u>                                                                                                                   |                                                          |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                      |  |                                                       | 8. DATE OF BIRTH<br><u>03-11-18</u>                                                                                                       |                                                          |  |
| 9. AGE (In years last birthday)<br><u>54</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                       | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                            |                                                          |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Pittsburg, Pa.</u>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                       | 12. CITIZEN OF WHAT COUNTRY?                                                                                                              |                                                          |  |
| 13. FATHER'S NAME<br><u>EDWARD JOHNSON</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                       | 14. MOTHER'S MAIDEN NAME<br><u>EVA WATSON</u>                                                                                             |                                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                       | 16. SOCIAL SECURITY NO.                                                                                                                   |                                                          |  |
| 17. INFORMANT<br><u>Mildred Miller 1826 N. Dallas St.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                       | ADDRESS                                                                                                                                   |                                                          |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>INSTANTANEOUS</u><br><u>1 month</u><br><u>1 year</u>                                   |                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                       | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                          |  |
| 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                      |                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                       | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                   |                                                          |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                       | 21D. TIME OF INJURY (APPROX.)                                                                                                             |                                                          |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                       | 21F. HOW DID INJURY OCCUR?                                                                                                                |                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/4 1972</u> to <u>9/9 1972</u><br>that (I) (we) last saw the deceased alive on <u>9/9 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                    |  |                                                       |                                                                                                                                           |                                                          |  |
| 23A. SIGNATURE<br><u>Craig R. Smith M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                       | 23B. DATE SIGNED<br><u>9/9/72</u>                                                                                                         |                                                          |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>CRAIG R. SMITH M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                       | 23D. ADDRESS<br><u>601 N. BROADWAY, BALT., M.D., 21205</u>                                                                                |                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 24B. DATE<br><u>9/13/72</u>                           |                                                                                                                                           | 24C. NAME of CEMETERY or CREMATORY<br><u>Int. Auburn</u> |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Balt. Md</u>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 13 1972</u> |                                                                                                                                           | 25B. NAME OF REGISTRAR<br><u>Andrew Whitson</u>          |  |
| 25C. FUNERAL DIRECTOR<br><u>Joseph L. Locks</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 25D. ADDRESS<br><u>1304 Central St</u>                |                                                                                                                                           | 25E. DATE<br><u>9/13/72</u>                              |  |

SECRET

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

RE: [illegible]

DATE: [illegible]

[illegible]

CONFIDENTIAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

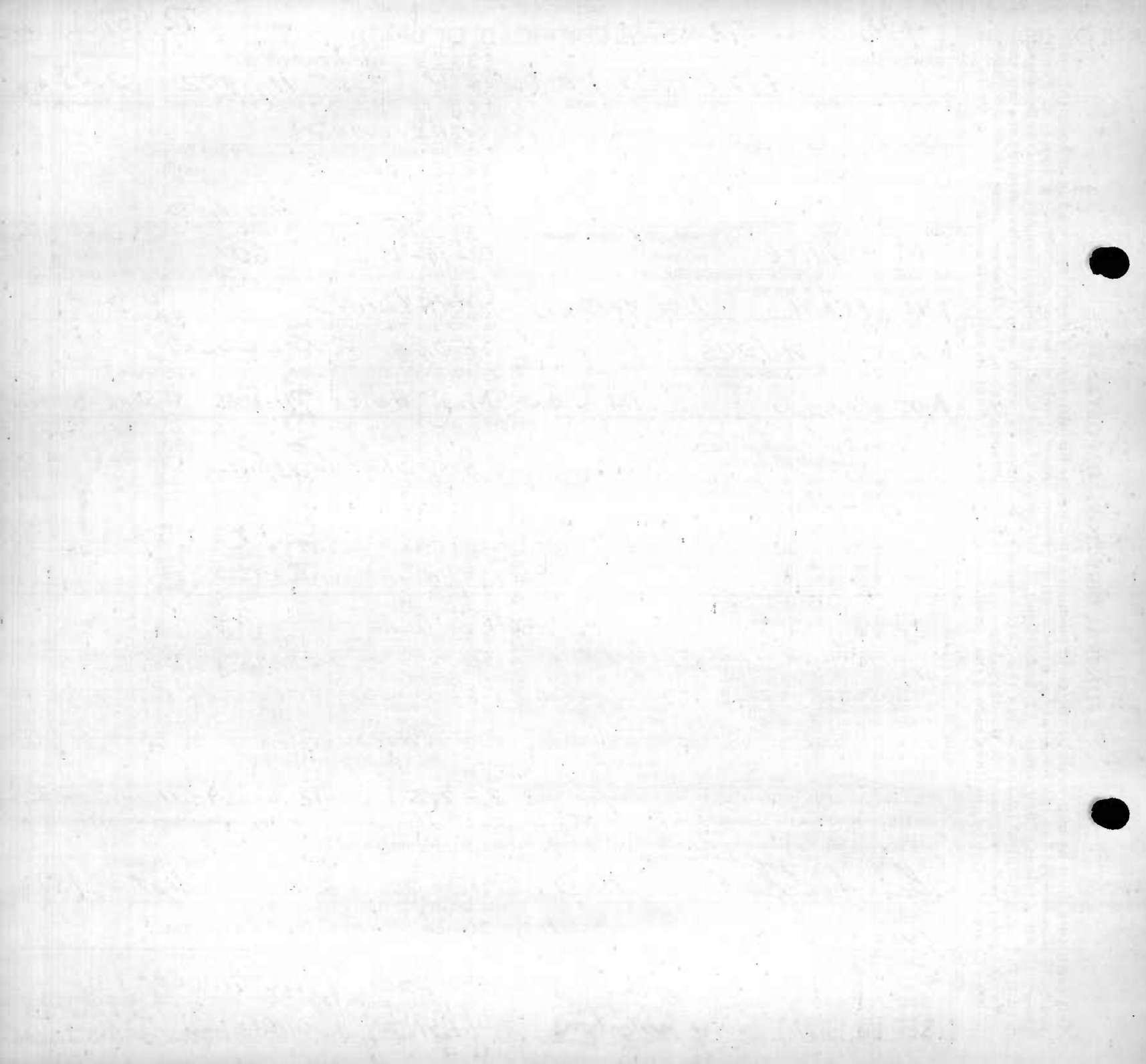
|                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                   |                                                                                                                                 |                                                           |                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| 7-362                                                                                                                                                                                                                                                                                                                                               |                         | 72 08780                                                                                                                                                    |                                   | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                |                                                           | REG. NO. 12 08780                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                           |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>TEETERS, JESS</b>                                                                                                 |                                   |                                                                                                                                 |                                                           | 2. DATE AND HOUR OF DEATH<br><b>9/7/72</b> <b>1:15</b> M.                                     |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                           |                                                           |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>BOLTON HILL NURSING HOME</b><br><b>1400 W. LAFAYETTE AVENUE</b>                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                   | A. STATE<br><b>MARYLAND</b>                                                                                                     |                                                           | 8. COUNTY<br><b>202</b>                                                                       |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                   | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                             |                                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                   | E. STREET AND NUMBER<br><b>11 S. BROADWAY</b>                                                                                   |                                                           | STREET <b>21231</b>                                                                           |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                               | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/1/06</b> | 9. AGE (in years last birthday)<br><b>64</b>                                                                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |                                                                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                       |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>UNKNOWN</b>                                                                                                         |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>GREENSPRING W. VA.</b>                                                          |                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                    |  |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                   | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>                                                                                      |                                                           |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>UNKNOWN</b> <b>UNKNOWN</b>                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                   | 16. SOCIAL SECURITY NO.<br><b>235-16-5693</b>                                                                                   |                                                           | 17. INFORMANT<br><b>ADMISSION RECORD</b>                                                      |  |
| 18. <b>250.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b>                                                                                                          |                         |                                                                                                                                                             |                                   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <b>malabsorptive syndrome</b>                                            |                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b>                                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.)                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                   | (B) <b>Diabetes mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                 |                                                           | <b>years</b>                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                   | (C) <b>Generalized arteriosclerosis</b>                                                                                         |                                                           | <b>years</b>                                                                                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                   |                                                                                                                                 |                                                           |                                                                                               |  |
| 19A. DATE OF OPERATION<br><b>9/7/72</b>                                                                                                                                                                                                                                                                                                             |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                   | 20A. AUTOPSY? (Yes or No)                                                                                                       |                                                           | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)                                                                                                                                                                                                                                                               |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                        |                                                           |                                                                                               |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                           |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                   | 21F. HOW DID INJURY OCCUR?                                                                                                      |                                                           |                                                                                               |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>9/22</b> 19 <b>70</b> to <b>9/7</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>9/7</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                   |                                                                                                                                 |                                                           |                                                                                               |  |
| 23A. SIGNATURE<br><b>Alan H. Martin MD</b>                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                   | Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                                           | 23B. DATE SIGNED<br><b>9/7/72</b>                                                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ALAN H MARTIN MD</b>                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                   | 23D. ADDRESS<br><b>21231 S. BROADWAY BALTIMORE MD 21202</b>                                                                     |                                                           |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>                                                                                                                                                                                                                                                                                          |                         | 24B. DATE<br><b>9-8-72</b>                                                                                                                                  |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>CORN ANATOMY BOARD</b>                                                                 |                                                           | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MD</b>                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><b>Anthony Thornton</b>                                                                                                           |                                   | 25C. FUNERAL DIRECTOR<br><b>Kaymond Curran</b>                                                                                  |                                                           | ADDRESS<br><b>8175 South St. Baltimore MD 21201</b>                                           |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | REG. NO. 72 08781                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| 72 08781 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | STATE OF MARYLAND-DHMH                                                                                                                                   |
| BIRTH NO. P-120                                                                                                                                                                                                                                                                                              |  | 1. NAME OF DECEASED (Type or Print) PHIPPS, EDWARD                                                     |  |                                                                                                                                                          |
| 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                                                                                                    |  | SEPT 11, 1972 2:45 A.M.                                                                                |  |                                                                                                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |  |                                                                                                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                    |  | A. STATE B. COUNTY                                                                                     |  |                                                                                                                                                          |
| Union Memorial Hospital                                                                                                                                                                                                                                                                                      |  | MARYLAND BALTO 5300                                                                                    |  |                                                                                                                                                          |
| 5. SEX M                                                                                                                                                                                                                                                                                                     |  | 6. RACE WHITE                                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                             |  | 9. AGE (In years last birthday)                                                                        |  | 10. CITIZEN OF WHAT COUNTRY?                                                                                                                             |
| 01-19-1912                                                                                                                                                                                                                                                                                                   |  | 60                                                                                                     |  | U. S. A.                                                                                                                                                 |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                    |  | 12. CITIZEN OF WHAT COUNTRY?                                                                           |  |                                                                                                                                                          |
| MARYLAND                                                                                                                                                                                                                                                                                                     |  | U. S. A.                                                                                               |  |                                                                                                                                                          |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                            |  | 14. MOTHER'S MAIDEN NAME                                                                               |  |                                                                                                                                                          |
| MARTIN PHIPPS                                                                                                                                                                                                                                                                                                |  | EDNA RUTLEDGE                                                                                          |  |                                                                                                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                     |  | 16. SOCIAL SECURITY NO.                                                                                |  | 17. INFORMANT ADDRESS                                                                                                                                    |
| NOT KNOWN                                                                                                                                                                                                                                                                                                    |  | NOT KNOWN                                                                                              |  | Mrs. ANITA PHIPPS SAME AS ABOVE                                                                                                                          |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                           |  | CAUSE OF DEATH                                                                                         |  |                                                                                                                                                          |
| 492 X I                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                 |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory insufficiency                          |  |                                                                                                                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                            |  | (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Cor Pulmonale                                              |  |                                                                                                                                                          |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                    |  | (C) Emphysema                                                                                          |  |                                                                                                                                                          |
| II                                                                                                                                                                                                                                                                                                           |  | Congestive Heart Failure                                                                               |  |                                                                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                |
| D                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from 8-23 1972 to 9-11 1972, that (I) (we) last saw the deceased alive on Sept 11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                               |  | 23B. DATE SIGNED                                                                                       |  |                                                                                                                                                          |
| Luis Sirotzky                                                                                                                                                                                                                                                                                                |  | Sept 11, 1972                                                                                          |  |                                                                                                                                                          |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                 |  | 23D. ADDRESS                                                                                           |  |                                                                                                                                                          |
| LUI S SIROTZKY                                                                                                                                                                                                                                                                                               |  | M.D. Union Memorial Hospital.                                                                          |  |                                                                                                                                                          |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                    |  | 24B. DATE                                                                                              |  | 24C. NAME OF CEMETERY or CREMATORY                                                                                                                       |
| 9-11-72                                                                                                                                                                                                                                                                                                      |  | 9-11-72                                                                                                |  | U of M. Anatomy Board                                                                                                                                    |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                |  | 24E. FUNERAL DIRECTOR                                                                                  |  |                                                                                                                                                          |
| BALTIMORE, MD                                                                                                                                                                                                                                                                                                |  | RAYMOND CURRAN                                                                                         |  |                                                                                                                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                              |  | 25B. NAME OF REGISTRAR                                                                                 |  | 25C. ADDRESS                                                                                                                                             |
| SEP 13 1972                                                                                                                                                                                                                                                                                                  |  | D. J. H. H. H.                                                                                         |  | 817 SEARLE DR TOWSON, MD 21204                                                                                                                           |

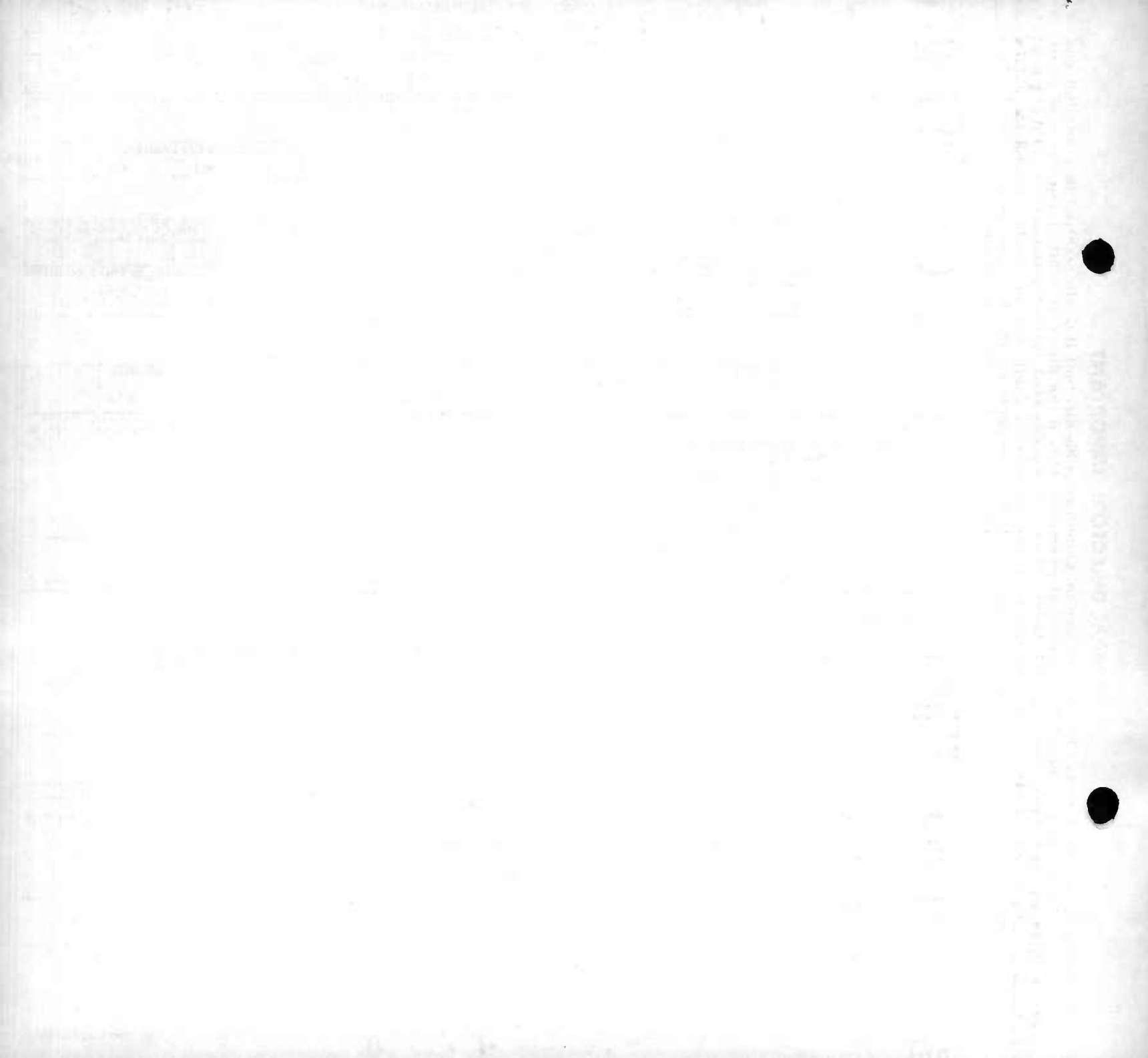




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                |                                              |                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------|
| C-462<br>72 08782                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | BALTIMORE CITY HEALTH DEPT.<br><b>CERTIFICATE OF DEATH</b>                                                                                       |                                                                                                                                                                                                                                                                                                                                | REG. NO.<br>72 08782                         |                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN CLARK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                  | 2. DATE AND HOUR OF DEATH<br><b>8/29/72</b> <b>6:22 P</b> <small>M.</small>                                                                                                                                                                                                                                                    |                                              |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MARYLAND GENERAL HOSP.<br/>827 LINDEN AVE.<br/>BALTIMORE, MD. 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1101</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1226 N. CALVERT ST.</b> |                                              |                                                             |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><b>BLACK</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/13</b>                                                                                                                                                                                                                                                                                               | 9. AGE (In years last birthday)<br><b>59</b> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NOT KNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>NOT KNOWN</b>                                                                                                                                                                                                                                                                          |                                              | 11. BIRTHPLACE (State or foreign country)<br><b>GEORGIA</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  | 13. FATHER'S NAME<br><b>NOT KNOWN</b>                                                                                                                                                                                                                                                                                          |                                              |                                                             |
| 14. MOTHER'S MAIDEN NAME<br><b>NOT KNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NOT KNOWN</b>                                                                                                                                                                                                   |                                              |                                                             |
| 16. SOCIAL SECURITY NO.<br><b>NOT KNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                  | 17. INFORMANT<br><b>HOSPITAL RECORDS.</b>                                                                                                                                                                                                                                                                                      |                                              |                                                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>431.01</b><br><b>CAUSE OF DEATH</b><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>(A) IMMEDIATE CAUSE</b> <b>Cerebral Hematoma (?)</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) CVA, probably cerebral hemorrhage</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) Hypertension</b><br><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>about 17 days</b><br><b>about 11 days</b><br><b>10 years</b> |                         |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                |                                              |                                                             |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>YES</b>                                                                                                                                                                                                                                                                 |                                              |                                                             |
| 20A. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                                                                                                                                                                                                                             |                                              |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>WHERE DID INJURY OCCUR</b><br>(If in Baltimore City, give exact location)                                                                                                                                                       |                                              |                                                             |
| 21C. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  | 21D. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                      |                                              |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 23</b> 19 <b>72</b> to <b>Aug. 29</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Aug. 29</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                |                                              |                                                             |
| 23A. SIGNATURE<br><b>RT MACAPRI</b> MD<br>DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                  | 23B. DATE SIGNED<br><b>8/29/72</b>                                                                                                                                                                                                                                                                                             |                                              |                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>RT MACAPRI</b> MD<br>DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                  | 23D. ADDRESS<br><b>827 LINDEN AVE., BALTO., MD 21201</b>                                                                                                                                                                                                                                                                       |                                              |                                                             |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>9-11-72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                  | 24B. DATE<br><b>9-11-72</b>                                                                                                                                                                                                                                                                                                    |                                              |                                                             |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>COFMARY BOARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MD.</b>                                                                                                                                                                                                                                                          |                                              |                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                  | 25B. NAME OF REGISTRAR<br><b>RAYMOND J. CURRAN</b>                                                                                                                                                                                                                                                                             |                                              |                                                             |
| 25C. FUNERAL DIRECTOR<br><b>817 SCARLETT DR. TOWSON, MD. 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                  | 25D. ADDRESS                                                                                                                                                                                                                                                                                                                   |                                              |                                                             |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

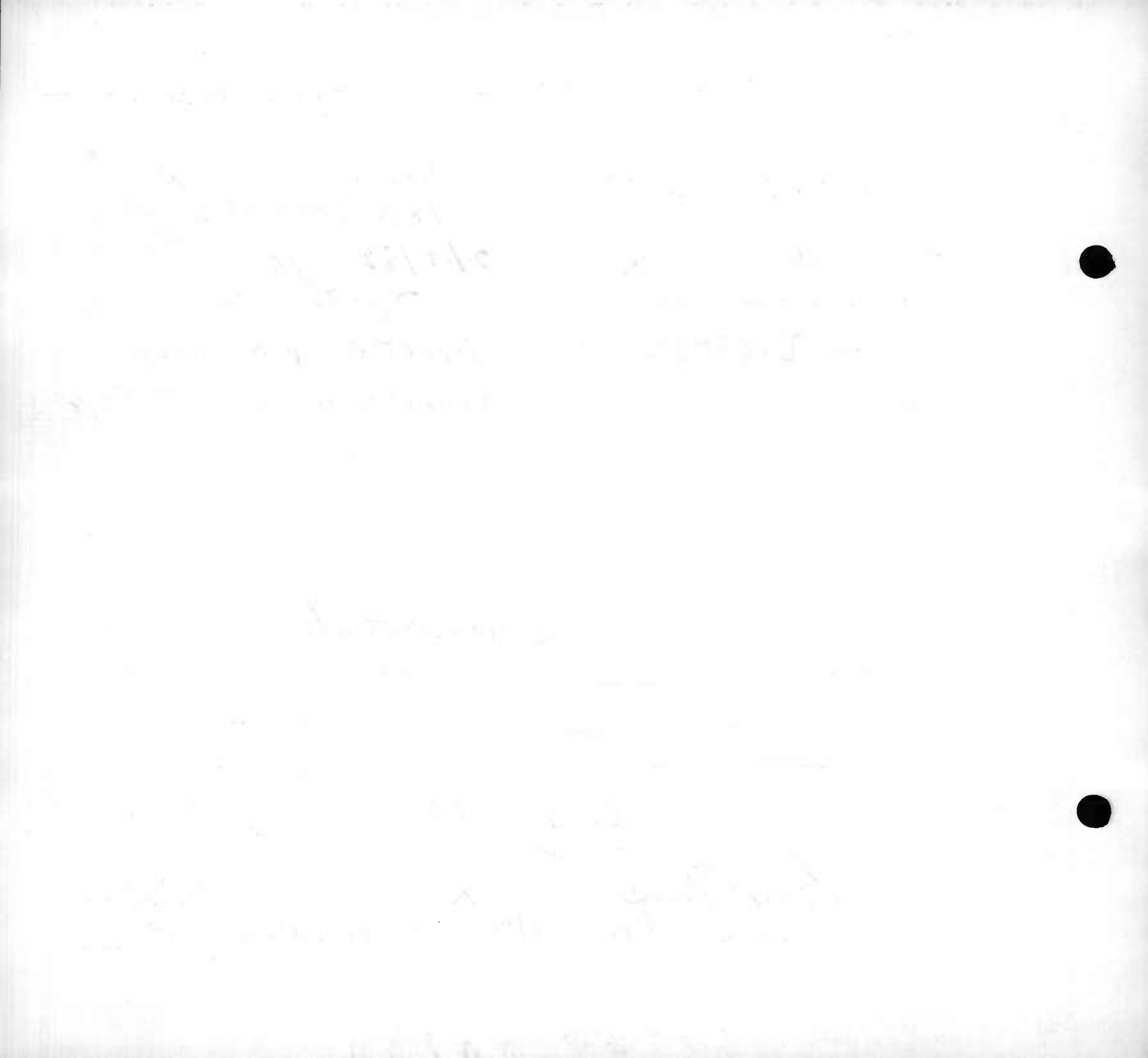
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                                                                                                                                                  | REG. NO. <b>72 08783</b>                                                 |                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------|
| BIRTH NO. <b>B-650 72-14395 72 08783</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |                                                                                                                                                  | STATE OF MARYLAND - DEATH                                                |                                   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Baby Boy Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        | 2. DATE AND HOUR OF DEATH<br><b>9-5-72 2:20 A.M.</b>                                                                                             |                                                                          |                                   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>37 MERCY HOSPITAL</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b><br>B. COUNTY <b>1002</b>             |                                                                          |                                   |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. RACE<br><b>N</b>                                                                                    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 8. DATE OF BIRTH<br><b>9-5-72</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                      |                                                                                                                                                  | 9. AGE (In years last birthday)<br><b>1 10</b>                           |                                   |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                     |                                                                          |                                   |
| 13. FATHER'S NAME<br><b>Jimmy Alderman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        | 14. MOTHER'S MAIDEN NAME<br><b>Carolyn Brown</b>                                                                                                 |                                                                          |                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16. SOCIAL SECURITY NO.                                                                                |                                                                                                                                                  | 17. INFORMANT ADDRESS                                                    |                                   |
| 18. <b>777X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>prematurity</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>N. A.</b>                                                                                     |                                                                          |                                   |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                                  | 20A. AUTOPSY? (Yes or No)                                                |                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                                                                                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> |                                                                                                                                                  | 21F. HOW DID INJURY OCCUR?                                               |                                   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> 19 <b>72</b> to <b>9/10</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9/5</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                        |  |                                                                                                        |                                                                                                                                                  |                                                                          |                                   |
| 23A. SIGNATURE<br><b>Ronald Shaffer M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                                                                                                  | 23B. DATE SIGNED<br><b>9/10/72</b>                                       |                                   |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                                                                                                                  | 23D. ADDRESS                                                             |                                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>9-13-72</b>                                                                            |                                                                                                                                                  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Hospital Disposal</b>           |                                   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR<br><b>Didney</b>                                                                |                                                                                                                                                  | 25C. FUNERAL DIRECTOR<br><b>MORTUARY SERVICE - BCHD</b>                  |                                   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

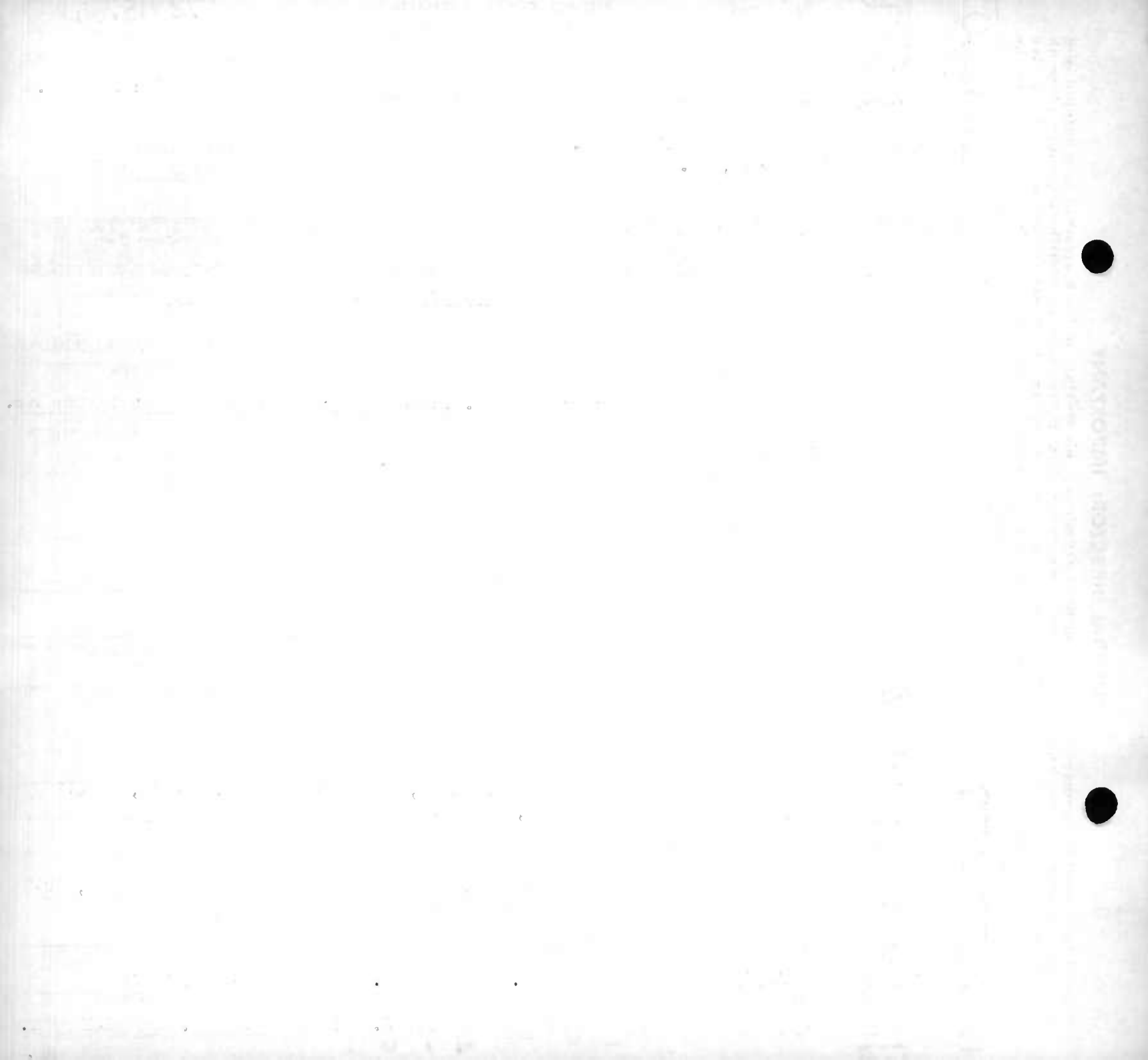
|                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  |                                                                                                                                 |                                              |                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| B-460                                                                                                                                                                                                                                                                                                                                 |                     | 72 08784                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                |                                              | REG. NO. 72 08784                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                                                            |                                              |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ESTELLE BLAIR</b>                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>Sept 7 1972 140 A M.</b>                                                                        |                                              |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY                     |                                              |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1800 CASADEL AVE</b>                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  | C. CITY OR TOWN<br><b>BALTO</b>                                                                                                 |                                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | E. STREET AND NUMBER<br><b>1800 CASADEL AVE</b>                                                                                 |                                              |                                                                                               |  |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/12/82</b>                                                                                              | 9. AGE (In years lost birthday)<br><b>90</b> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                       |                     | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><b>?(State) USA</b>                                                                |                                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                    |  |
| 13. FATHER'S NAME<br><b>? — BROTHERTON</b>                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>Annette PLATTINGLY</b>                                                                           |                                              |                                                                                               |  |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                 |                     | 16. SOCIAL SECURITY NO.<br><b>NONE</b>                                                                                                                      |  | 17. INFORMANT<br><b>FRANCES BLAIR</b>                                                                                           |                                              | ADDRESS<br><b>1800 CASADEL AVE</b>                                                            |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>ASCUD</b>                                                                                                                    |                     |                                                                                                                                                             |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                             |                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>                                      |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                        |                     |                                                                                                                                                             |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                             |                                              |                                                                                               |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                             |  |                                                                                                                                 |                                              |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Osteoarthritis</b>                                                                                                                                                                       |                     |                                                                                                                                                             |  |                                                                                                                                 |                                              | <b>?</b>                                                                                      |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                    |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                       |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                 |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                        |                                              |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                             |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |  | 21F. HOW DID INJURY OCCUR?                                                                                                      |                                              |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 19 72</b> to <b>Sept 7 19 72</b> that (I) (we) last saw the deceased alive on <b>Sept 6 19 72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                             |  |                                                                                                                                 |                                              |                                                                                               |  |
| 23A. SIGNATURE<br><b>Earc Pass</b>                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                              | 23B. DATE SIGNED<br><b>9/7/72</b>                                                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>I. EARC PASS MD</b>                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 23D. ADDRESS<br><b>4001 WILKENS AVE</b>                                                                                         |                                              |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                              |                     | 24B. DATE<br><b>9-13-72</b>                                                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATOR<br><b>ANATOMY BOARD OF MARYLAND</b>                                                           |                                              | 24D. LOCATION (City, town, or County) (State)                                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                 |                     | 25B. NAME OF REGISTRAR<br><b>Lidney Johnson</b>                                                                                                             |  | 25C. FUNERAL DIRECTOR<br><b>UNIVERSITY MEDICAL SCHOOL</b>                                                                       |                                              | ADDRESS<br><b>MORTUARY SERVICE - BCHD</b>                                                     |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                                              | 72 08785                                                                                                                                                                                            |                                                                      | 72 08785                                                                           |                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------|
| C-462                                                                                                                                                                                                                                                                                                                              |              |                                                                                                                                                             |                                              | 72 08785                                                                                                                                                                                            |                                                                      | 72 08785                                                                           |                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                             |                                              | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                              |                                                                      | 2. DATE AND HOUR OF DEATH                                                          |                                               |
|                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |                                              | Clark Yvonne                                                                                                                                                                                        |                                                                      | 9/11/72 11:00 P.M.                                                                 |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |                                              | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)<br>A. STATE                                                                                                   |                                                                      | B. COUNTY                                                                          |                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>38 Provident Hospital                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |                                              | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Height Ave.<br>Baltimore, Md. 21215                                                                                         |                                                                      | C. CITY OR TOWN<br>Baltimore                                                       |                                               |
|                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |                                              |                                                                                                                                                                                                     |                                                                      | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                               |
|                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |                                              | E. STREET AND NUMBER<br>720 Newington Ave.                                                                                                                                                          |                                                                      |                                                                                    |                                               |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                   | 6. RACE<br>C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>2/26/39                  | 9. AGE (In years last birthday)<br>33                                                                                                                                                               | 10. Under 1 Yr. Months: Days:                                        | 11. Under 24 Hrs. Hours: Min.                                                      |                                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>PRINTER                                                                                                                                                                                                                             |              |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY            |                                                                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country)<br>TRINIDAD, PRINCESS TOWN |                                                                                    | 12. CITIZEN OF WHAT COUNTRY?<br>**** TRINIDAD |
| 13. FATHER'S NAME<br>ASHTON CUPID                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br>CLARISSA DRAYTON |                                                                                                                                                                                                     | PRINCESS TOWN TRINIDAD                                               |                                                                                    |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                     |              |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br>216-68-5299       |                                                                                                                                                                                                     | 17. INFORMANT<br>Mr. Herbert Clark (Husband)                         |                                                                                    |                                               |
|                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |                                              |                                                                                                                                                                                                     | ADDRESS<br>720 Newington Ave.                                        |                                                                                    |                                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |              |                                                                                                                                                             |                                              | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Massive Pulmonary Embolism<br>Phlebo-Thrombosis of deep pelvic & leg vein<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>hours                              |                                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                   |              |                                                                                                                                                             |                                              |                                                                                                                                                                                                     |                                                                      |                                                                                    |                                               |
| 19A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                        |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                              | 20A. AUTOPSY? (Yes or No)<br>Yes                                                                                                                                                                    |                                                                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                              |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                              | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                         |                                                                      |                                                                                    |                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                          |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                              | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                          |                                                                      |                                                                                    |                                               |
| 22. I certify that (I) (this hospital) attended the deceased from September 7, 1972 to September 11, 1972 that (I) (we) last saw the deceased alive on September 11, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |              |                                                                                                                                                             |                                              |                                                                                                                                                                                                     |                                                                      |                                                                                    |                                               |
| 23A. SIGNATURE<br>Rifat Abouy                                                                                                                                                                                                                                                                                                      |              |                                                                                                                                                             |                                              | 23B. DATE SIGNED<br>September 11, 1972                                                                                                                                                              |                                                                      |                                                                                    |                                               |
| 23C. PHYSICIAN'S NAME (Type)<br>Rifat Abouy MD                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                             |                                              | 23D. ADDRESS<br>2300 Cameron Blvd                                                                                                                                                                   |                                                                      |                                                                                    |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                 |              | 24B. DATE<br>9/17/72                                                                                                                                        |                                              | 24C. NAME of CEMETERY or CREMATORY<br>PRINCESS TOWN ST. STEPHENS CEM.                                                                                                                               |                                                                      | 24D. LOCATION<br>PRINCESS TOWN TRINIDAD                                            |                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 13 1972                                                                                                                                                                                                                                                                                     |              | 25B. NAME OF REGISTRAR<br>Andrew Johnson                                                                                                                    |                                              | 25C. FUNERAL DIRECTOR<br>WILLIAM J. SPICER                                                                                                                                                          |                                                                      | ADDRESS<br>1639 N. BROADWAY BALT.                                                  |                                               |

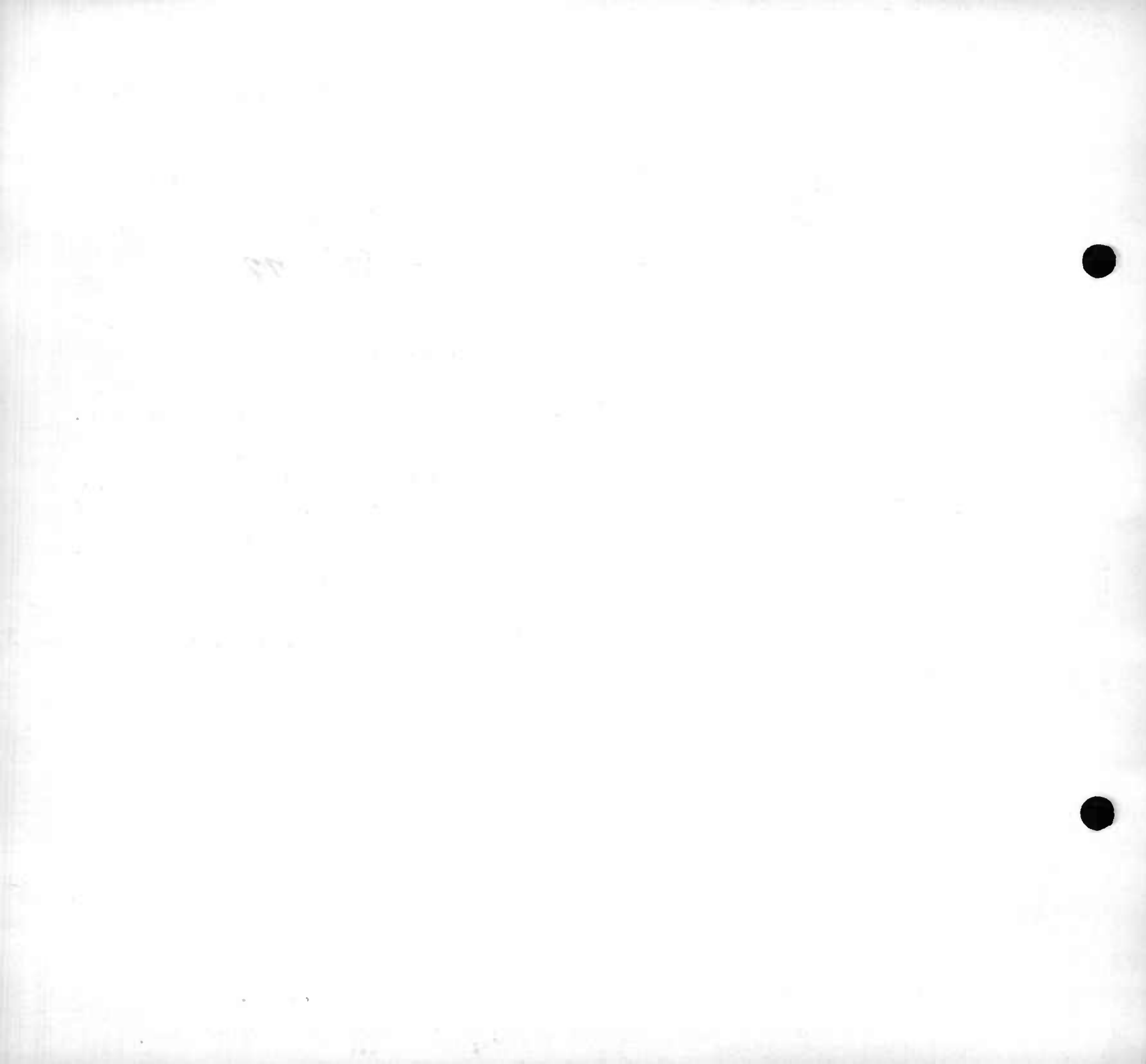




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                     |  |  |  | 72 08786                                                                                                                                                                                       |  | 72 08786 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                            |  |  |  | CERTIFICATE OF DEATH                                                                                                                                                                           |  |          |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                               |  |  |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                                      |  |          |  |
| Mrs. Alice L. Johnson                                                                                                                                                                                                                                                                                                                |  |  |  | 9/10/72 8:20 P.M.                                                                                                                                                                              |  |          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                               |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                          |  |          |  |
| Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)<br>Barns Secours Hospital<br>2025 W. Myrtle St.<br>Bldg. Bld. 21223                                                                                                                                                        |  |  |  | A. STATE Maryland<br>B. COUNTY 2001                                                                                                                                                            |  |          |  |
| 5. SEX F                                                                                                                                                                                                                                                                                                                             |  |  |  | 6. RACE Negro                                                                                                                                                                                  |  |          |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                          |  |  |  | 8. DATE OF BIRTH 7-6-95                                                                                                                                                                        |  |          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                          |  |  |  | 9. AGE (in years last birthday) 77                                                                                                                                                             |  |          |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                    |  |  |  | 11. BIRTHPLACE (State or foreign country) Maryland                                                                                                                                             |  |          |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                    |  |  |  | 12. CITIZEN OF WHAT COUNTRY? USA                                                                                                                                                               |  |          |  |
| 14. MOTHER'S MAIDEN NAME Annie Hall                                                                                                                                                                                                                                                                                                  |  |  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                       |  |          |  |
| 16. SOCIAL SECURITY NO. 215-10-3746D                                                                                                                                                                                                                                                                                                 |  |  |  | 17. INFORMANT Mary Johnson 2009 Renrose Ave.                                                                                                                                                   |  |          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary infarct, bilateral.<br>(B) ASHD vs. cor. arteriosclerosis years<br>(C) Chronic myelomonocytosis, several years |  |          |  |
| 19. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                              |  |  |  | 20. AUTOPSY (Yes or No) Yes                                                                                                                                                                    |  |          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                       |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                       |  |          |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                             |  |  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                      |  |          |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                               |  |  |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                     |  |          |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8 6 1972 to 9 10 72 that (I) (we) last saw the deceased alive on 9 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                |  |  |  | 23A. SIGNATURE Bhargava                                                                                                                                                                        |  |          |  |
| 23B. DATE SIGNED 9 10 1972                                                                                                                                                                                                                                                                                                           |  |  |  | 23C. PHYSICIAN'S NAME (Type) Bhargava                                                                                                                                                          |  |          |  |
| 23D. ADDRESS Barn Secours Hospital                                                                                                                                                                                                                                                                                                   |  |  |  | 24. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery                                                                                                                                           |  |          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                      |  |  |  | 24B. DATE 9-14-72                                                                                                                                                                              |  |          |  |
| 24C. LOCATION (City, town, or county) (State) Balto., Md.                                                                                                                                                                                                                                                                            |  |  |  | 25A. DATE REC'D BY HEALTH DEPT. SEP 13 1972                                                                                                                                                    |  |          |  |
| 25B. NAME OF REGISTRAR                                                                                                                                                                                                                                                                                                               |  |  |  | 25C. FUNERAL DIRECTOR Wm C March 928 E North Ave.                                                                                                                                              |  |          |  |
| 25D. ADDRESS                                                                                                                                                                                                                                                                                                                         |  |  |  | 25E. ADDRESS                                                                                                                                                                                   |  |          |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08787

BIRTH NO.

STATE OF MARYLAND-DEME

1. NAME OF DECEASED  
(Type or Print)

WILLIAM LEE Jr.

2. DATE OF DEATH  
Known ☐ Month Day Year Hour  
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital (DOA)

3. DATE PRONOUNCED DEAD  
Month Day Year Hour  
9 10 1972 7:25 p M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md. B. COUNTY 1510

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

11-16-57

10. AGE (In years  
lost birthday)

14

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3818 Dolphin Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William J. Lee Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sylvia Phenix

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Geraldine Barry 2105 Homewood Ave

19. E 965X

CAUSE OF DEATH

Gunshot wound of neck

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

4500 blk. Garrison Blvd. 1510

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

9-10-72 7:05 p m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by unknown assailant.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-11-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-14-72

24C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 13 1972

25B. NAME OF REGISTRAR

Sydney W. Houston

25C. FUNERAL DIRECTOR

Wm C March 928 E North Ave.

ADDRESS

3818 DOLFIELD AVE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                          |                                                                                                                    |                                                                                                                             |                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| BIRTH NO. 72 08788                                                                                                                                                                                                                                                                                                             |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                         |                                                                                                                    | REG. NO. 72 08788                                                                                                           |                                                            |
| 1. NAME OF DECEASED (Type or Print) <i>M. Anna Rappold</i>                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                          |                                                                                                                    | 2. DATE AND HOUR OF DEATH <i>9-11-72 10:20 P</i>                                                                            |                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                          |                                                                                                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                       |                                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1400 John St Boston Hill Nursing Home</i>                                                                                                                                                                         |                  |                                                                                                                                                          |                                                                                                                    | A. STATE <i>Maryland</i> B. COUNTY <i>606 S. Lehigh St.</i>                                                                 |                                                            |
|                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                          |                                                                                                                    | C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                            |
|                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                          |                                                                                                                    | E. STREET AND NUMBER <i>606 S. Lehigh St. 2607</i>                                                                          |                                                            |
| 5. SEX <i>F</i>                                                                                                                                                                                                                                                                                                                | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>4/18/86</i>                                                                                    | 9. AGE (In years last birthday) <i>86</i>                                                                                   | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>                                                                                                                                                                                                                   |                  |                                                                                                                                                          | 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>                                                                      |                                                                                                                             | 11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>  |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                          | 13. FATHER'S NAME <i>John Henry BLEN den back</i>                                                                  |                                                                                                                             |                                                            |
| 14. MOTHER'S MAIDEN NAME <i>Anna Reinder bach</i>                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                          | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> |                                                                                                                             |                                                            |
| 16. SOCIAL SECURITY NO. <i>812-94-9529</i>                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                          | 17. INFORMANT <i>Mission Records</i> ADDRESS                                                                       |                                                                                                                             |                                                            |
| 18. <i>433.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                               |                  |                                                                                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                       |                                                                                                                             |                                                            |
| 1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.                                                                                                                                                                                  |                  |                                                                                                                                                          | (A) IMMEDIATE CAUSE <i>cerebrovascular with paralytic right</i>                                                    |                                                                                                                             |                                                            |
| 2. ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                          | (B) <i>Pericardial failure</i>                                                                                     |                                                                                                                             |                                                            |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last                                                                                                                                                                                                                       |                  |                                                                                                                                                          | (C) <i>arteriosclerosis generalized</i>                                                                            |                                                                                                                             |                                                            |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                            |                  |                                                                                                                                                          |                                                                                                                    |                                                                                                                             |                                                            |
| 19A. DATE OF OPERATION <i>0</i>                                                                                                                                                                                                                                                                                                |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                                                                    | 20A. AUTOPSY? (Yes or No)                                                                                                   |                                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indicate medical examiner)                                                                                                                                                                                                               |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                    |                                                            |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                      |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                    | 21F. HOW DID INJURY OCCUR?                                                                                                  |                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/30</i> 19 <i>72</i> and that (I) (we) last saw the deceased alive on <i>9/11</i> 19 <i>72</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                          |                                                                                                                    |                                                                                                                             |                                                            |
| 23A. SIGNATURE <i>Al Martin</i>                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                          |                                                                                                                    | 23B. DATE SIGNED <i>9/11/72</i>                                                                                             |                                                            |
| 23C. PHYSICIAN'S NAME (Type) <i>Alan N. Maecht MD</i>                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                          |                                                                                                                    | 23D. ADDRESS <i>2 E Pearl St Balt Md 21202</i>                                                                              |                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>                                                                                                                                                                                                                                                                         |                  | 24B. DATE <i>9-15-72</i>                                                                                                                                 |                                                                                                                    | 24C. NAME OF CEMETERY OR CREMATORY <i>MT. CARMEL CEM.</i>                                                                   |                                                            |
| 24D. LOCATION (City, town, or county) <i>BALTO., MD.</i>                                                                                                                                                                                                                                                                       |                  | 24E. DATE REC'D BY HEALTH DEPT. <i>SEP 13 1972</i>                                                                                                       |                                                                                                                    | 24F. NAME OF REGISTRAR <i>Lidnyshnikov</i>                                                                                  |                                                            |
| 24G. FUNERAL DIRECTOR <i>W. J. Moore</i>                                                                                                                                                                                                                                                                                       |                  | 24H. ADDRESS <i>-2334 Jefferson St</i>                                                                                                                   |                                                                                                                    |                                                                                                                             |                                                            |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   | REG. NO. <b>72 08789</b>                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>WILLIAM G. HEMELT, SR.</b>                                                                                                                                                                                                                                                                                                                    |                         | <b>72 08789</b><br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                   |                                                                                                              |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br><b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b><br><b>31</b><br>Baltimore City Hospitals<br>4940 Eastern Ave.<br>Balto., 21224, Md.                                                                                                                                |                         | <b>2. DATE AND HOUR OF DEATH</b><br><b>September 7, 1972</b> <b>5:20 P. M.</b><br><br><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> Md. <b>B. COUNTY</b> <b>2609</b><br><br><b>C. CITY OR TOWN</b> Baltimore <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><br><b>E. STREET AND NUMBER</b><br>3604 Fait Ave. # 21224. |                                   |                                                                                                              |
| <b>5. SEX</b><br>Male                                                                                                                                                                                                                                                                                                                                                                                              | <b>6. RACE</b><br>White | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                                                                                                                        | <b>8. DATE OF BIRTH</b><br>9-3-92 | <b>9. AGE</b> (In years last birthday) 80<br><b>11. BIRTHPLACE</b> (State or foreign country) Baltimore, Md. |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Retired                                                                                                                                                                                                                                                                                                      |                         | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br>U.S. Postal Serv.                                                                                                                                                                                                                                                                                                                                                                                  |                                   |                                                                                                              |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                      |                         | <b>13. FATHER'S NAME</b><br>William Hemelt                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                                                                                                              |
| <b>14. MOTHER'S MAIDEN NAME</b><br>Anna Schlunt                                                                                                                                                                                                                                                                                                                                                                    |                         | <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br>Yes W.W. I                                                                                                                                                                                                                                                                                                               |                                   |                                                                                                              |
| <b>16. SOCIAL SECURITY NO.</b><br>218-36-9051                                                                                                                                                                                                                                                                                                                                                                      |                         | <b>17. INFORMANT</b><br>Melba E. Hemelt :                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                                                                                                              |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>myocardial infarction</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Coronary occlusion</i><br>(C) <i>h/d</i> |                         | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><i>several hrs</i><br><br><br><i>&gt; 1 hr</i>                                                                                                                                                                                                                                                                                                                                          |                                   |                                                                                                              |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                                                               |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                                                                              |
| <b>19A. DATE OF OPERATION</b><br>0                                                                                                                                                                                                                                                                                                                                                                                 |                         | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                   |                                                                                                              |
| <b>20A. AUTOPSY?</b> (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                   |                         | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                                                                                                                                                                                                                                                                                                                                                                    |                                   |                                                                                                              |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)                                                                                                                                                                                                                                                                                                                       |                         | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                |                                   |                                                                                                              |
| <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                    |                         | <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                         |                                   |                                                                                                              |
| <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                   |                         | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                                   |                                                                                                              |
| <b>22. I certify that (I) (this hospital) attended the deceased from 8/5 1971 to 9/7 1972, that (I) (we) last saw the deceased alive on 8/5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>                                                                                                      |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                   |                                                                                                              |
| <b>23A. SIGNATURE</b><br><i>J. J. Platt</i>                                                                                                                                                                                                                                                                                                                                                                        |                         | <b>23B. DATE SIGNED</b><br>9/9/72                                                                                                                                                                                                                                                                                                                                                                                                              |                                   |                                                                                                              |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br>JAY J. PLATT                                                                                                                                                                                                                                                                                                                                                                |                         | <b>23D. ADDRESS</b><br>6003 Stuart Ave., Balto., Md.                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                                                                                                              |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                          |                         | <b>24B. DATE</b><br>9-11-72                                                                                                                                                                                                                                                                                                                                                                                                                    |                                   |                                                                                                              |
| <b>24C. NAME OF CEMETERY or CREMATORY</b><br>Sacred Heart Cemetery                                                                                                                                                                                                                                                                                                                                                 |                         | <b>24D. LOCATION</b> (City, town, or county)<br>7401 German Hill Rd., BA. CO. Md.                                                                                                                                                                                                                                                                                                                                                              |                                   |                                                                                                              |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br>SEP 13 1972                                                                                                                                                                                                                                                                                                                                                              |                         | <b>25B. NAME OF REGISTRAR</b><br><i>Andrew H. ...</i>                                                                                                                                                                                                                                                                                                                                                                                          |                                   |                                                                                                              |
| <b>25C. FUNERAL DIRECTOR</b><br><i>Phyllis G. ...</i>                                                                                                                                                                                                                                                                                                                                                              |                         | <b>ADDRESS</b><br>901 S. Cocklin St. Balto., 21224, Md.                                                                                                                                                                                                                                                                                                                                                                                        |                                   |                                                                                                              |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                                                  | REG. NO. 72 08730                                                                                                           |                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| M-200 72 08730                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                                  | STATE OF MARYLAND-DEATH                                                                                                     |                                               |
| BIRTH NO. <u>Balto Co. Md.</u>                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                                  | 1. NAME OF DECEASED<br>(Type or Print) <u>Karen J. Mack</u>                                                                 |                                               |
| 2. DATE AND HOUR OF DEATH<br><u>4:38pm 9/7/72</u>                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                                                                                                                                  | 4:38P. M. <u>4:38P. M.</u>                                                                                                  |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                       |                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>33 Johns Hopkins Hospital</u>                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                                                                                                                                                                  | A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>                                                                              |                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                                                                  | C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                               |
| E. STREET AND NUMBER<br><u>1641 GRAY HAVEN COURT, #21222</u>                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                  |                                                                                                                             |                                               |
| 5. SEX<br><u>FEMALE</u>                                                                                                                                                                                                                                                                                                                                                          | 6. RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-22-69</u>                                                                                                                                               | 9. AGE (in years last birthday)<br><u>2</u>                                                                                 | 10. Under 1 Yr. Months: Days: Hours: Min.     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CHILD</u>                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><u>BALTIMORE, MD.</u>                                                                                                               |                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
| 13. FATHER'S NAME<br><u>Kenneth Mack</u>                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>JANET LINZ.</u>                                                                                                                                   |                                                                                                                             |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>—</u>                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><u>—</u>                                                                                                                                              |                                                                                                                             | 17. INFORMANT<br><u>KENNETH MACK</u>          |
|                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                                                                  |                                                                                                                             | ADDRESS<br><u>SAME.</u>                       |
| 18. <u>746.81</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                            |                         |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Deceased Cardiac Output</u><br>(B) <u>UNKNOWN myocardopathy</u><br>(C) <u>CONGENITAL HEART BLOCK</u> |                                                                                                                             |                                               |
|                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u><br><u>Birth - Death</u><br><u>" "</u>                                                                                |                                                                                                                             |                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>NONE</u>                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                                                                  |                                                                                                                             |                                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                  | 20A. AUTOPSY? (Yes or No)                                                                                                   |                                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                          |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                    |                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                        |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                  | 21F. HOW DID INJURY OCCUR?                                                                                                  |                                               |
| 22. I certify that (1) (this hospital) attended the deceased from <u>9/4/72</u> 19 <u>72</u> to <u>9/7/72</u> 19 <u>72</u> that (2) (we) last saw the deceased alive on <u>9/7</u> 19 <u>72</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. — <u>Autopsy Pending</u> |                         |                                                                                                                                                             |                                                                                                                                                                                  |                                                                                                                             |                                               |
| 23A. SIGNATURE<br><u>James L. Sutphen MD</u>                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                  | 23B. DATE SIGNED<br><u>9/7/72</u>                                                                                           |                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>James L. Sutphen MD</u>                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                                                  | 23D. ADDRESS<br><u>4400-30 Chelset Court Baltimore Md. 21206</u>                                                            |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                        |                         | 24B. DATE<br><u>9-11-72</u>                                                                                                                                 |                                                                                                                                                                                  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>HOLY REDEEMER CEM.</u>                                                             |                                               |
| 24D. LOCATION<br><u>4430 BELAIR RD. BALTO., MD.</u>                                                                                                                                                                                                                                                                                                                              |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 13 1972</u>                                                                                                       |                                                                                                                                                                                  |                                                                                                                             |                                               |
| 25B. NAME OF REGISTRAR<br><u>Andrew H. [illegible]</u>                                                                                                                                                                                                                                                                                                                           |                         | 25C. FUNERAL DIRECTOR<br><u>Charles E. [illegible]</u>                                                                                                      |                                                                                                                                                                                  | 25D. ADDRESS<br><u>9015 CONKLING ST BALTO. 21224, MD.</u>                                                                   |                                               |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-250 72 08731                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                      |                                              | REG. NO. 72 08731                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                   |                             |                                                                                                                                                             |  | STATE OF MARYLAND-DEMB                                                                                                |                                              |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BEJMA, MARY, TERESA</b>                                                                                                                                                                                                                                                                           |                             |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>SEPT. 7, 1972, 6:35 P.M.</b>                                                          |                                              |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                      |                             |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                 |                                              |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>BALTIMORE CITY HOSPITALS<br/>4940 Eastern Ave<br/>Baltimore, Md. 21224</b>                                                                                                                                                  |                             |                                                                                                                                                             |  | A. STATE <b>Maryland</b><br>B. COUNTY <b>101</b>                                                                      |                                              |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                             |                             |                                                                                                                                                             |  | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                   |                                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                             |                             |                                                                                                                                                             |  | E. STREET AND NUMBER<br><b>3108 ELLIOTT ST. #21224</b>                                                                |                                              |                                                                                               |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>Caucasian</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-16-03</b>                                                                                    | 9. AGE (In years last birthday)<br><b>69</b> | 10. Under 1 Yr. Months: Days: Hours: Min.                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WORK</b>                                                                                                                                                                                                                            |                             |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                                                   |                                              | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             |  | 13. FATHER'S NAME<br><b>Sabastian HOCK</b>                                                                            |                                              |                                                                                               |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Teresa MATHIAS</b>                                                                                                                                                                                                                                                                                           |                             |                                                                                                                                                             |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b> |                                              |                                                                                               |  |
| 16. SOCIAL SECURITY NO.<br><b>213-05-2397</b>                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             |  | 17. INFORMANT<br>BCH: Records: <b>4940 Eastern Ave. ADDRESS<br/>Baltimore, Md. 21224</b>                              |                                              |                                                                                               |  |
| 18. <b>56791</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE MYOCARDIAL INFARCTION</b>                                                                                     |                             |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b>                                                         |                                              |                                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Parkinson's disease</b>                                                                                                                                                                                |                             |                                                                                                                                                             |  | (B) <b>gastrointestinal bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>1/2 day</b>                             |                                              |                                                                                               |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                            |                             |                                                                                                                                                             |  |                                                                                                                       |                                              |                                                                                               |  |
| 19A. DATE OF OPERATION<br><b>NO</b>                                                                                                                                                                                                                                                                                                         |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                       |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                           |                                              |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?<br><b>6pm</b>                                                                              |                                              |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Sep 7, 1972</b> to <b>6:35 AM Sep 7, 1972</b> that (I) (we) last saw the deceased alive on <b>Sep 7, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |                                                                                                                                                             |  |                                                                                                                       |                                              |                                                                                               |  |
| 23A. SIGNATURE<br><b>Robert H. Fletcher</b>                                                                                                                                                                                                                                                                                                 |                             |                                                                                                                                                             |  | 23B. DATE SIGNED<br><b>Sep 7, 1972</b>                                                                                |                                              | 23C. PHYSICIAN'S NAME (Type)<br><b>Robert Fletcher M.D.</b>                                   |  |
| 23D. ADDRESS<br><b>Baltimore City Hospitals<br/>4940 Eastern Ave. Baltimore, Md. 21224</b>                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             |  |                                                                                                                       |                                              |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                   |                             | 24B. DATE<br><b>9-11-72</b>                                                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>SACRED HEART CEM.</b>                                                        |                                              | 24D. LOCATION (City, town, or county) (State)<br><b>7401 GERMAN HILL RD. BALTO., MD.</b>      |  |
| 25A. DATE RECD BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                        |                             | 25B. NAME OF REGISTRAR<br><b>1972000</b>                                                                                                                    |  | 25C. FUNERAL DIRECTOR<br><b>901 S. CONKLIN ST. BALTO., MD.</b>                                                        |                                              |                                                                                               |  |

45112# 70710122 2018

## SANITAM

HOCK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                                                               |                                                                      |                                                                     |                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------|
| B-634 72 08792                                                                                                                                                                                                                                                                                          |                                                                                         | BALTIMORE CITY HEALTH DEPT.                                                                   |                                                                      | 72 08792                                                            |                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                               |                                                                                         | STATE OF MARYLAND - DISTRICT                                                                  |                                                                      | REG. NO.                                                            |                               |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                  |                                                                                         | 2. DATE AND HOUR OF DEATH                                                                     |                                                                      |                                                                     |                               |
| Olga M. Bertulis                                                                                                                                                                                                                                                                                        |                                                                                         | 12:30 AM 9/10/72                                                                              |                                                                      |                                                                     |                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                  |                                                                                         | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)          |                                                                      |                                                                     |                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)                                                                                                                                                                                            |                                                                                         | A. STATE                                                                                      |                                                                      | B. COUNTY                                                           |                               |
|                                                                                                                                                                                                                                                                                                         |                                                                                         | Maryland                                                                                      |                                                                      |                                                                     |                               |
| Maryland General Hospital                                                                                                                                                                                                                                                                               |                                                                                         | C. CITY OR TOWN                                                                               |                                                                      | D. INSIDE CITY LIMITS?                                              |                               |
|                                                                                                                                                                                                                                                                                                         |                                                                                         | Baltimore                                                                                     |                                                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |
|                                                                                                                                                                                                                                                                                                         |                                                                                         | E. STREET AND NUMBER                                                                          |                                                                      |                                                                     |                               |
|                                                                                                                                                                                                                                                                                                         |                                                                                         | 628 S. Eaton St. #21224                                                                       |                                                                      |                                                                     |                               |
| 5. SEX                                                                                                                                                                                                                                                                                                  | 6. RACE                                                                                 | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>         | 8. DATE OF BIRTH                                                     | 9. AGE (In years last birthday)                                     | 10. UNDER 1 Yr. Months: Days  |
| FEMALE                                                                                                                                                                                                                                                                                                  | WHITE                                                                                   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                            | 4-7-21                                                               | 51                                                                  | 11. UNDER 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                             |                                                                                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                             |                                                                      | 11. BIRTHPLACE (State or foreign country)                           |                               |
| EXAMINER                                                                                                                                                                                                                                                                                                |                                                                                         | L.C. ISAACS CO.                                                                               |                                                                      | BALTIMORE, Maryland                                                 |                               |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                       |                                                                                         | 14. MOTHER'S MAIDEN NAME                                                                      |                                                                      | 12. CITIZEN OF WHAT COUNTRY?                                        |                               |
| CHARLES BARANTAS                                                                                                                                                                                                                                                                                        |                                                                                         | MARY GIRULIS                                                                                  |                                                                      | U.S.A.                                                              |                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                |                                                                                         | 16. SOCIAL SECURITY NO.                                                                       |                                                                      | 17. INFORMANT                                                       |                               |
| NO                                                                                                                                                                                                                                                                                                      |                                                                                         | 213-16-9166                                                                                   |                                                                      | FRED C. BARANTAS                                                    |                               |
|                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                                                               |                                                                      | ADDRESS<br>920 N. STREEPER ST.<br>BALTO. 21205, MD.                 |                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                      |                                                                                         | CAUSE OF DEATH                                                                                |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |                               |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                            |                                                                                         | I                                                                                             |                                                                      | 4 years                                                             |                               |
|                                                                                                                                                                                                                                                                                                         |                                                                                         | Carcinoma of the breast,                                                                      |                                                                      |                                                                     |                               |
|                                                                                                                                                                                                                                                                                                         |                                                                                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>metastatic to liver, bone, and lung |                                                                      |                                                                     |                               |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                       |                                                                                         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                           |                                                                      |                                                                     |                               |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                               |                                                                                         | (C)                                                                                           |                                                                      |                                                                     |                               |
| II                                                                                                                                                                                                                                                                                                      |                                                                                         |                                                                                               |                                                                      |                                                                     |                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                        |                                                                                         |                                                                                               |                                                                      |                                                                     |                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                        | 20A. AUTOPSY? (Yes or No)                                                                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                     |                               |
| NO                                                                                                                                                                                                                                                                                                      |                                                                                         | NO                                                                                            |                                                                      |                                                                     |                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                                      |                                                                     |                               |
|                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                                                               |                                                                      |                                                                     |                               |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                           | 21E. INJURY OCCURRED                                                                    | 21F. HOW DID INJURY OCCUR?                                                                    |                                                                      |                                                                     |                               |
|                                                                                                                                                                                                                                                                                                         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |                                                                                               |                                                                      |                                                                     |                               |
| 22. I certify that (1) (this hospital) attended the deceased from 9/2 1972 to 9/10 1972 that (1) (we) last saw the deceased alive on 9/10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |                                                                                         |                                                                                               |                                                                      |                                                                     |                               |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                          |                                                                                         | 23B. DATE SIGNED                                                                              |                                                                      |                                                                     |                               |
| A. Serpick M.D.                                                                                                                                                                                                                                                                                         |                                                                                         | 9/10/72                                                                                       |                                                                      |                                                                     |                               |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                            |                                                                                         | 23D. ADDRESS                                                                                  |                                                                      |                                                                     |                               |
| Arthur Serpick M.D.                                                                                                                                                                                                                                                                                     |                                                                                         | 1114 St. Paul St. 21201 Baltimore, Maryland                                                   |                                                                      |                                                                     |                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                | 24B. DATE                                                                               | 24C. NAME OF CEMETERY OR CREMATORY                                                            | 24D. LOCATION (City, town, or county) (State)                        |                                                                     |                               |
| BURIAL                                                                                                                                                                                                                                                                                                  | 9-13-72                                                                                 | GARDENS OF FAITH                                                                              | KENWOOD AVE TRUMPS MILL RD. BALTO., MD.                              |                                                                     |                               |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                         | 25B. NAME OF REGISTRAR                                                                  | 25C. FUNERAL DIRECTOR                                                                         | ADDRESS                                                              |                                                                     |                               |
| SEP 13 1972                                                                                                                                                                                                                                                                                             | [Signature]                                                                             | [Signature]                                                                                   | 901 S. CONKLING ST. BALTO., 21224, MD.                               |                                                                     |                               |

1912  
JAN 12  
MAY 12  
JUL 12  
SEP 12  
NOV 12  
DEC 12

1913  
JAN 13  
MAY 13  
JUL 13  
SEP 13  
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DEC 13

1914  
JAN 14  
MAY 14  
JUL 14  
SEP 14  
NOV 14  
DEC 14

1915  
JAN 15  
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1918  
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SEP 18  
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DEC 18

1919  
JAN 19  
MAY 19  
JUL 19  
SEP 19  
NOV 19  
DEC 19

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |  | REG. NO. 72 08793                                                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| T-653                                                                                                                                                                                                                                                                                                                                             |  | 72 08793                                                                                                                                   |  | CERTIFICATE OF DEATH                                                                                                                                        |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                         |  | 1. NAME OF DECEASED<br>(Type or Print)<br><i>Thornton, Florence</i>                                                                        |  | 2. DATE AND HOUR OF DEATH<br><i>9-10-72</i> <i>4:15 P.M.</i>                                                                                                |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><i>Bon Secours Hospital</i>                                                                                                                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY <i>1902</i> |  | 5. CITY OR TOWN <i>Baltimore</i>                                                                                                                            |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Bon Secours Hospital</i><br><i>Fayette St</i>                                                                                                                                                                                                                                                          |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                       |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  |
| 5. SEX <i>F</i>                                                                                                                                                                                                                                                                                                                                   |  | 6. RACE <i>Black</i>                                                                                                                       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><i>1-11-17</i>                                                                                                                                                                                                                                                                                                                |  | 9. AGE (in years last birthday)<br><i>55</i>                                                                                               |  | 10. AGE (in years last birthday)<br>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Unemployed</i>                                                                                                                                                                                                                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  | 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>                                                                                                |  |
| 13. FATHER'S NAME<br><i>John Miller</i>                                                                                                                                                                                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><i>Gertrude Franklin</i>                                                                                       |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>Unknown</i>                                  |  |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                           |  | 17. INFORMANT                                                                                                                              |  | ADDRESS                                                                                                                                                     |  |
| 18. <i>427.01</i>                                                                                                                                                                                                                                                                                                                                 |  | CAUSE OF DEATH                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                    |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Congestive heart failure</i>                                                     |  |                                                                                                                                                             |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                    |  | (B) <i>C.H.F., Liver failure and uremia</i>                                                                                                |  |                                                                                                                                                             |  |
| (C) _____                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                            |  |                                                                                                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                  |  |                                                                                                                                            |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                         |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-22-72</i> 19 to <i>9-10</i> 19 <i>72</i><br>that (I) (we) last saw the deceased alive on <i>9-10</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><i>Bhargava</i>                                                                                                                                                                                                                                                                                                                 |  | DEGREE                                                                                                                                     |  | 23B. DATE SIGNED<br><i>9-10-72</i>                                                                                                                          |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>BHARGAVA</i>                                                                                                                                                                                                                                                                                                   |  | DEGREE<br><i>M.D.</i>                                                                                                                      |  | 23D. ADDRESS<br><i>BON SECOURS Hospital, Baltimore Md.</i>                                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                         |  | 24B. DATE<br><i>9/14/72</i>                                                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt Airy</i>                                                                                                        |  |
| 24D. LOCATION<br><i>Baltimore Md</i>                                                                                                                                                                                                                                                                                                              |  | 24E. DATE REC'D BY HEALTH/DEPT.<br><i>SEP 13 1972</i>                                                                                      |  | 24F. NAME OF REGISTRAR<br><i>Andrew Thornton</i>                                                                                                            |  |
| 24G. FUNERAL DIRECTOR<br><i>George Rice</i>                                                                                                                                                                                                                                                                                                       |  | ADDRESS<br><i>1300 Eastward Pl</i>                                                                                                         |  |                                                                                                                                                             |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CLINTON BOYKINS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                                                                       |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>46 LUTHERAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 9, 1972 1:12 P.M.</b>                                                                                                                             |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                      |  |
| 7. RACE<br><b>Negro</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                              |  |
| 9. DATE OF BIRTH<br><b>11/1/07</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (In years last birthday) <b>64</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                                                                                             |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                    |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br><b>Idora Hopwell</b>                                                                                                                                                                 |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.                                                                                                                                                                                          |  |
| 18. INFORMANT<br><b>Willie Mae Boykin</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | ADDRESS<br><b>2335 W. Mosher St.</b>                                                                                                                                                                             |  |
| 19. <b>412.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                        |  | CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |
| 20A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                 |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)                                                                                                                         |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                        |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                       |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br><br>DATE SIGNED <b>9/10/72</b> |  |                                                                                                                                                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>9/15/72</b>                                                                                                                                                                                      |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Columbia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 24D. LOCATION (City, town, or county) (State)<br><b>Columbia, S. C.</b>                                                                                                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Arden H. Norton</b>                                                                                                                                                                 |  |
| 25C. FUNERAL DIRECTOR<br><b>Charles A. Rice</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | ADDRESS<br><b>1300 Eutaw Pl.</b>                                                                                                                                                                                 |  |

UNITED STATES

REPORT

OF THE

COMMISSIONER

OF THE

LAND OFFICE

AND

OF THE

GENERAL LAND OFFICE

WASHINGTON

1892

REPORT

OF THE

COMMISSIONER

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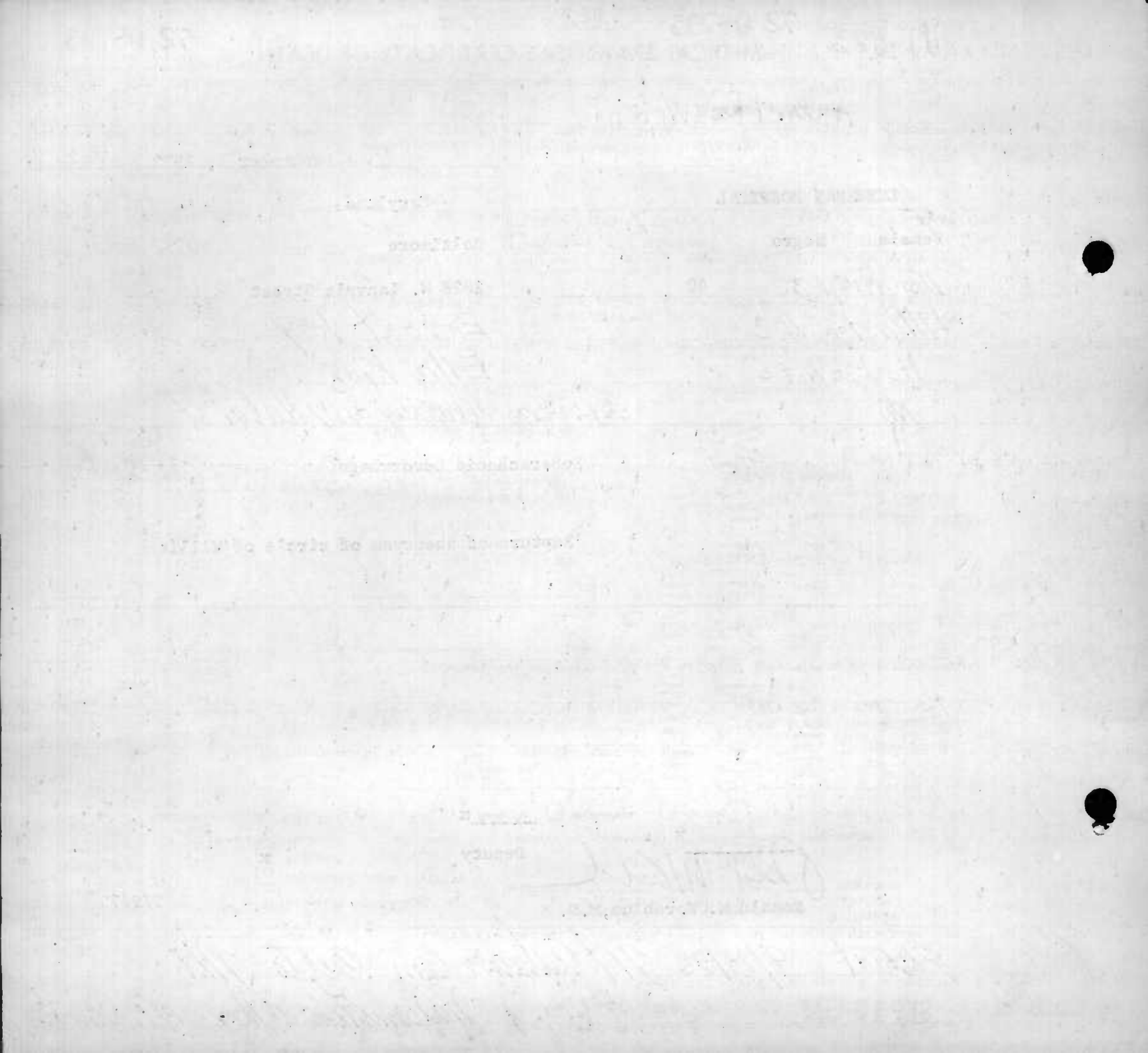
W-623 72 08795 STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT 72 08795

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Armetta Wright</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>LUTHERAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 8, 1972 10:20 P.</b>                        |  |
| 6. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7. RACE<br><b>Negro</b>                                                                                    |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                        |  |
| 9. DATE OF BIRTH<br><b>March 15, 1932</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10. AGE (In years lost birthday) <b>40</b>                                                                 |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Lillington N.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. CITIZEN OF WHAT COUNTRY?                                                                               |  |
| 13. FATHER'S NAME<br><b>Ernest Ray</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella King</b>                                                               |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16. KIND OF BUSINESS OR INDUSTRY                                                                           |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 18. SOCIAL SECURITY NO.<br><b>227-38-4272</b>                                                              |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Subarachnoid hemorrhage</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) IMMEDIATE CAUSE<br/>DUE TO, OR AS A CONSEQUENCE OF:<br/>(B) Rupture of aneurysm of circle of Willis<br/>DUE TO, OR AS A CONSEQUENCE OF:<br/>(C)</b>                                                                                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                               |  |
| 20. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                            |  |
| 21. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                            |  |
| 22. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                  |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22F. HOW DID INJURY OCCUR?                                                                                 |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>9/9/72</b><br>EXAMINER'S NAME (Type) |  |                                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 24B. DATE<br><b>9/13/72</b>                                                                                |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Paul's Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR<br><b>Sidney Johnson</b>                                                            |  |
| 25C. FUNERAL DIRECTOR<br><b>Williams Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25D. ADDRESS<br><b>319 N. Mohr St.</b>                                                                     |  |

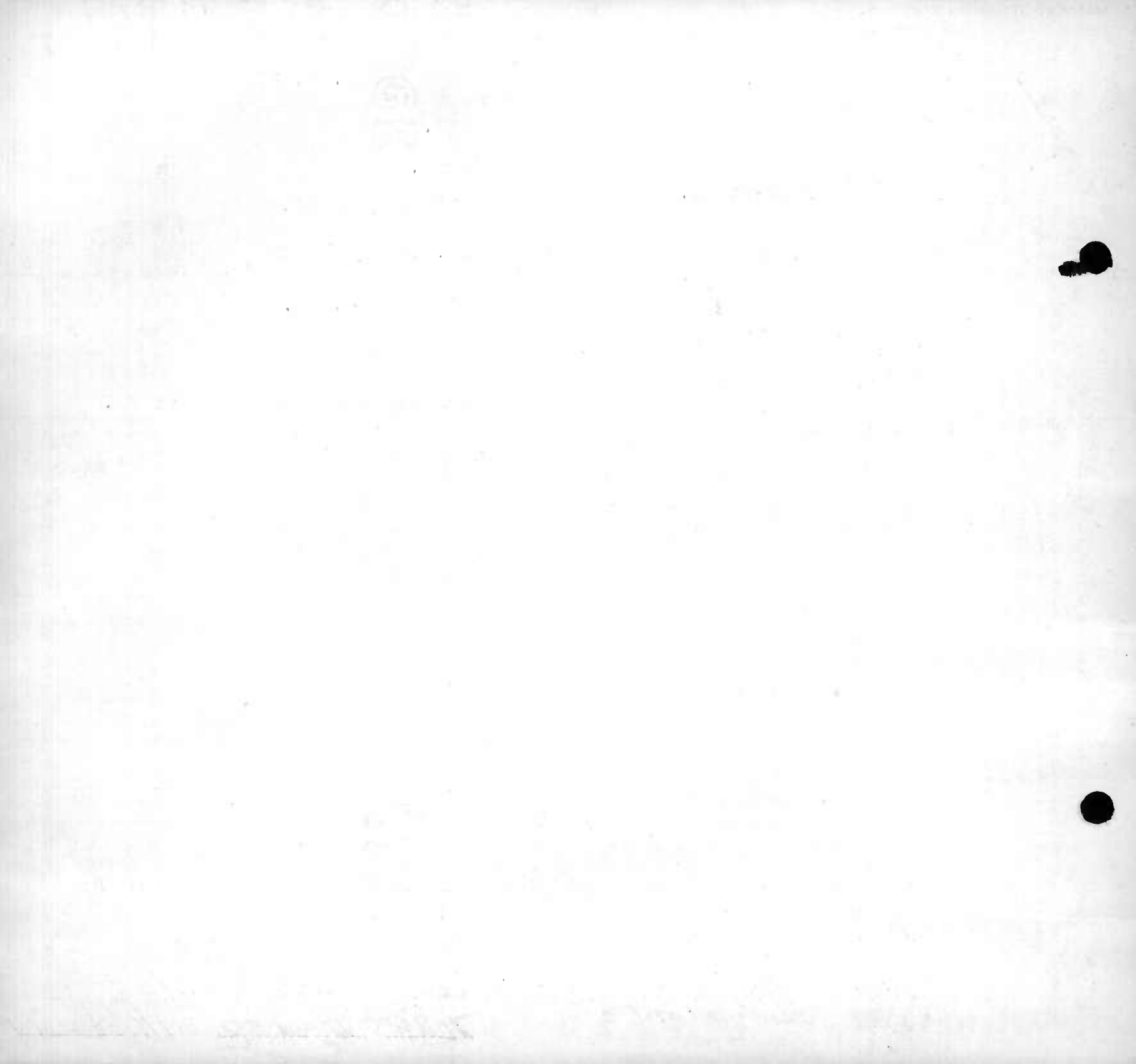
VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                            |                                                                                                                                                             | REG. NO. <span style="float: right;">72 08796</span>                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| BIRTH NO. <span style="float: right;">72 08796</span>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                            |                                                                                                                                                             | STATE OF MARYLAND - DIME                                                 |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                       |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                                  |                                                                                                                                                             |                                                                          |
| ADDIE GIBSON                                                                                                                                                                                                                                                                                                                                 |  | Sept. 8, 1972                                                                                                                                                                                                                              |                                                                                                                                                             |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                                      |                                                                                                                                                             |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>00 1020 Bennett Pl.                                                                                                                                                                                                                                                                              |  | A. STATE<br>Md.                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                          |
|                                                                                                                                                                                                                                                                                                                                              |  | B. COUNTY<br>1601                                                                                                                                                                                                                          |                                                                                                                                                             |                                                                          |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                             |  | 6. RACE<br>Colored                                                                                                                                                                                                                         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Oct. 4, 1891                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                                                     |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country)<br>Calvert Co. Md.                                                                                                | 12. CITIZEN OF WHAT COUNTRY?                                             |
| 13. FATHER'S NAME<br>Thomas Young                                                                                                                                                                                                                                                                                                            |  | 14. MOTHER'S MAIDEN NAME<br>Annie Dareus                                                                                                                                                                                                   |                                                                                                                                                             |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                               |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                    | 17. INFORMANT<br>Corrine Dumas 1020 Bennett Pl.                                                                                                             |                                                                          |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION lost. |  | CAUSE OF DEATH<br><br>cardiovascular disease<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____<br><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 years |                                                                                                                                                             |                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                           |                                                                                                                                                             | 20A. AUTOPSY? (Yes or No)                                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                   |                                                                                                                                                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                  |                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) (this hospital) attended the deceased from 7-9-63 19 to 9-8-72 19, that (I) (we) last saw the deceased alive on 9-8-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                    |  |                                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                          |
| 23A. SIGNATURE<br>William H. Watts                                                                                                                                                                                                                                                                                                           |  | 23B. DATE SIGNED<br>9/11/72                                                                                                                                                                                                                |                                                                                                                                                             | 23C. PHYSICIAN'S NAME (Type)<br>William H. Watts M.D.                    |
| 24A. BURIAL CREMATION REMOVAL (Specify)                                                                                                                                                                                                                                                                                                      |  | 24B. DATE                                                                                                                                                                                                                                  |                                                                                                                                                             | 24C. NAME OF CEMETERY OR CREMATORY                                       |
| Burial                                                                                                                                                                                                                                                                                                                                       |  | 9/13/72                                                                                                                                                                                                                                    |                                                                                                                                                             | St. Lukes Cem. Balto. Md.                                                |
| 25A. DATE REC'D BY HEALTH DEPT.<br>P 13 1972                                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR                                                                                                                                                                                                                     |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br>William H. Watts                                |



J-525

72 08797

STATE OF MARYLAND-DEMM  
BALTIMORE CITY HEALTH DEPARTMENT

72 08797

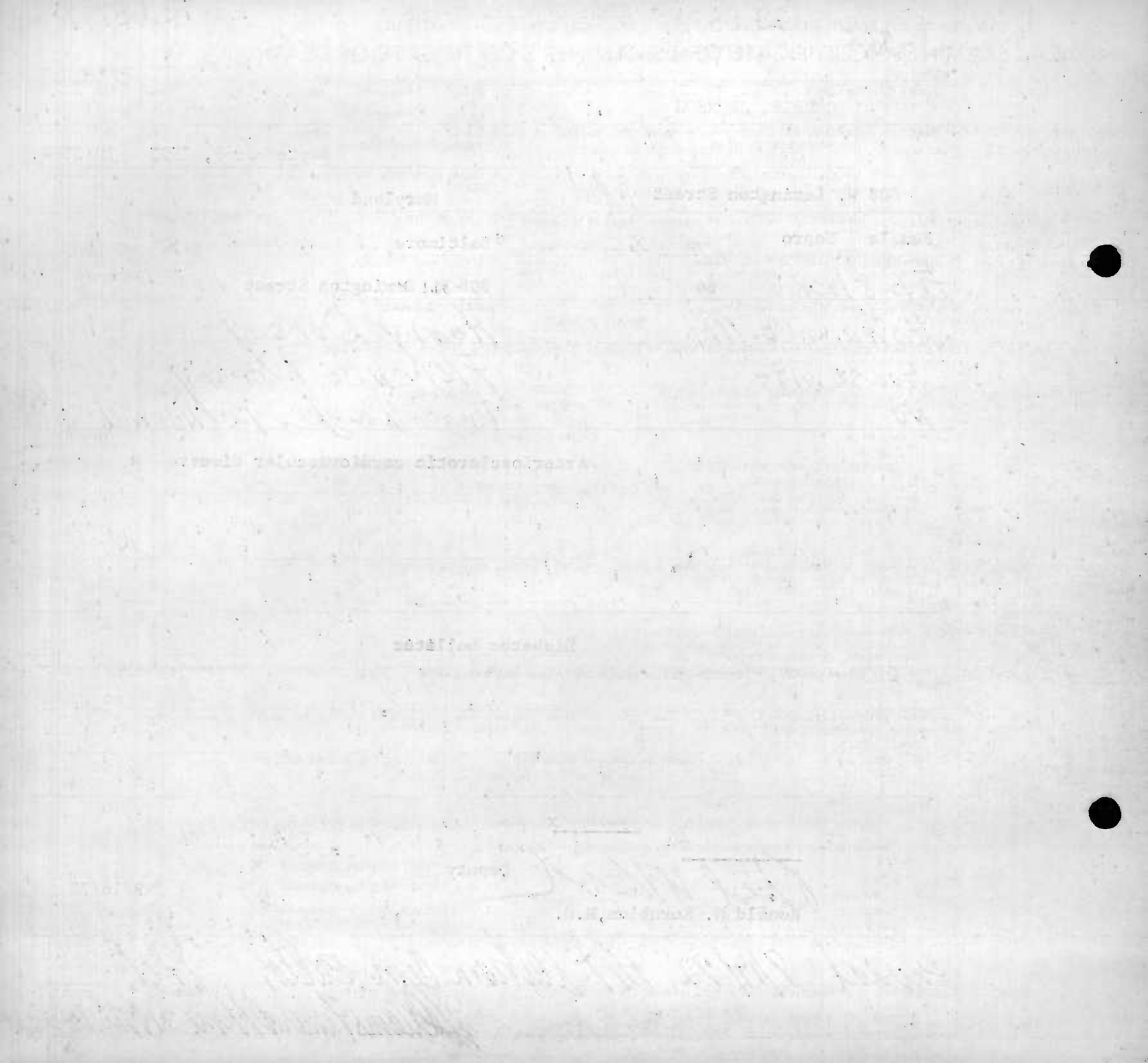
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

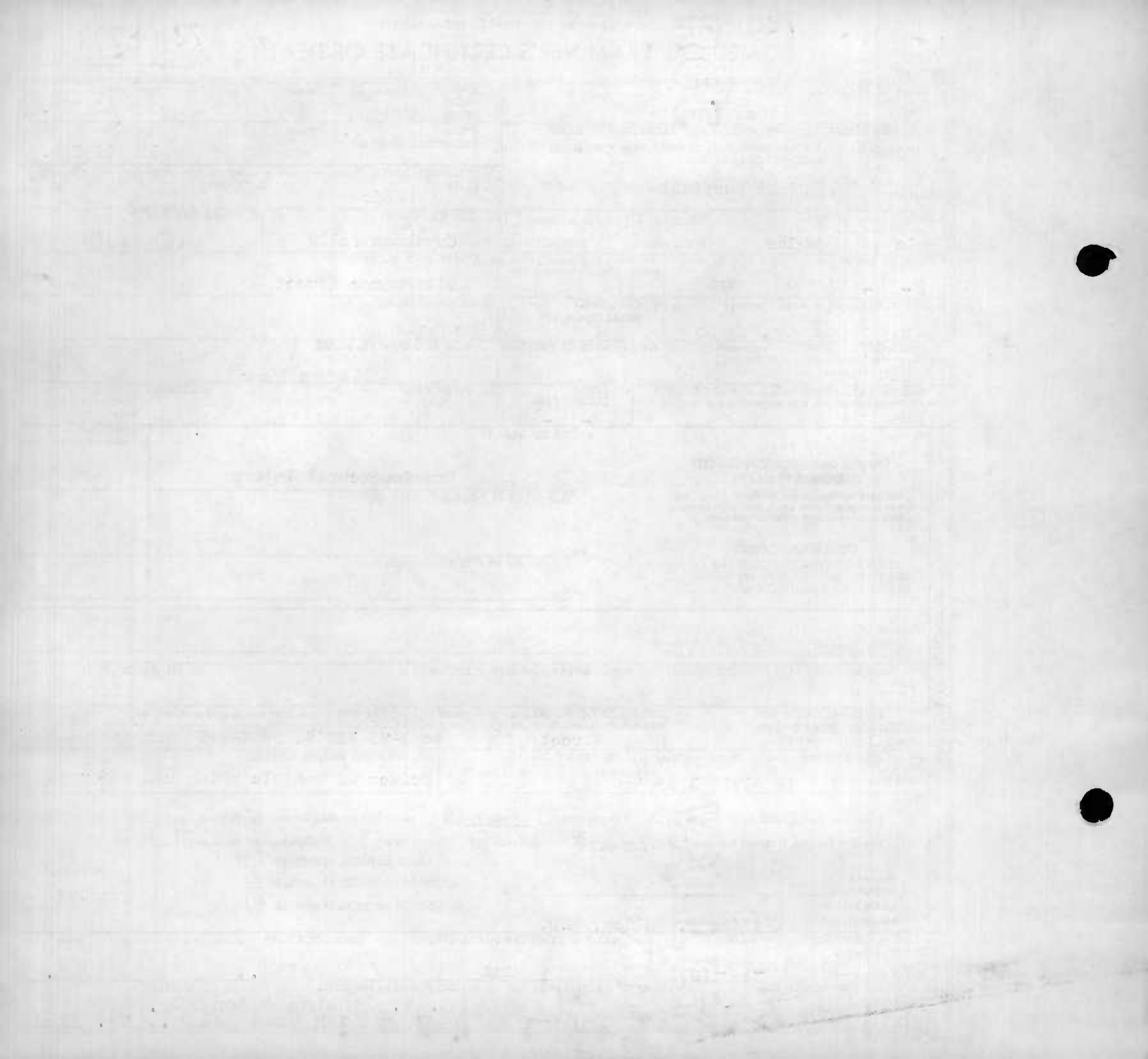
|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CARRIE JOHNSON</b>                                                                                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                                      |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>808 W. Lexington Street Apt. 11</b>                                                                                                                                                                                              |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 9, 1972 10:35 A.M.</b>                                                                                           |  |
| 6. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE<br><b>Negro</b>                                                                                                                                                         |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                             |  |
| D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                 |  |
| 9. DATE OF BIRTH<br><b>Feb. 8, 1908</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 10. AGE (In years last birthday)<br><b>64</b>                                                                                                                                   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Howard Co. Md.</b>                                                                                                                                                                                                                                                                                                                                            |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                    |  |
| 13. FATHER'S NAME<br><b>Henry Dorsey</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Florence Dorsey</b>                                                                                                                                                                                                                                                                                                                                                            |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                            |  |
| 17. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                       |  | 18. INFORMANT<br><b>Bruce Douglas</b>                                                                                                                                           |  |
| 19. <b>412.4 + 250.9</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b>                                                                                                                |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                          |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                              |  | (C)                                                                                                                                                                             |  |
| 20A. DATE OF OPERATION<br><b>9/14/72</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Diabetes mellitus</b>                                                                                                    |  |
| 21. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                 |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                        |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |  | 22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)                                                                                                              |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                                      |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                                 |  |
| ACTUAL EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>                                                                                                                                                                                                                                                                                                                                              |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br><b>9/10/72</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>9/14/72</b>                                                                                                                                                     |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Luke's Cemetery</b>                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>                                                                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Sidney W. Wilson</b>                                                                                                                               |  |
| 25C. FUNERAL DIRECTOR<br><b>William's Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br><b>319 N. Howard St.</b>                                                                                                                                             |  |







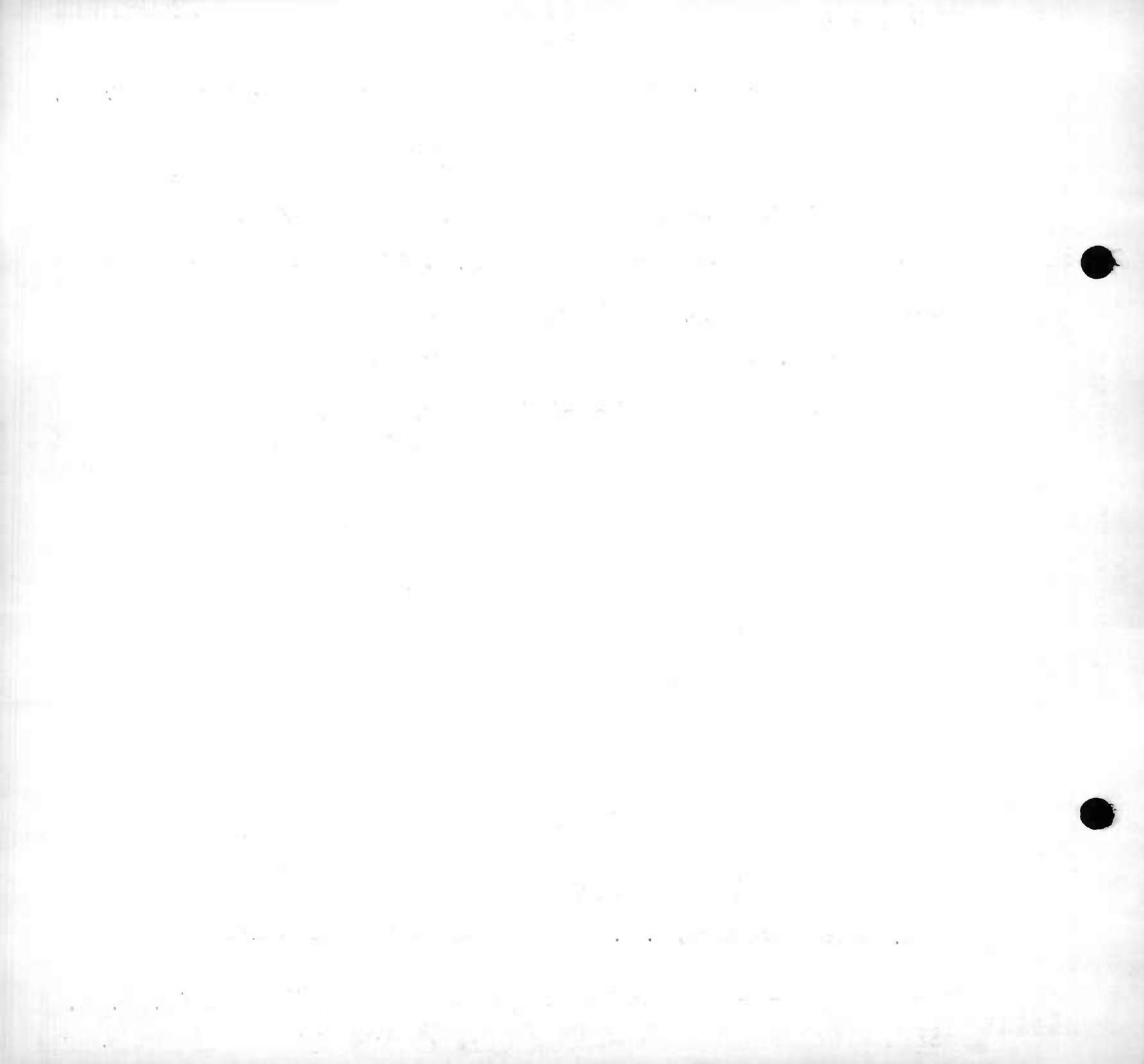
| STATE OF MARYLAND - DEMH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 72 08798                                                                                                                                                    |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                   |  | REG. NO. 72 08798                                                   |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  |                                                                                                                                                                                                           |  |                                                                     |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>L. Fred Houk</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>8</b> Day <b>19</b> Year <b>72</b> Hour <b>12:35P.</b> M.                                                                          |  |                                                                     |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Sinai Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |  | 3. DATE PRONOUNCED DEAD<br>Month <b>8</b> Day <b>19</b> Year <b>72</b> Hour <b>12:35P.</b> M.                                                                                                             |  |                                                                     |  |
| 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)<br>A. STATE <b>Ohio</b> B. COUNTY <b>V32</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |  | C. CITY OR TOWN <b>Cuyahoga Falls</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                     |  |                                                                     |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | E. STREET AND NUMBER<br><b>311 Monroe Street</b>                                                                                                                                                          |  |                                                                     |  |
| 9. DATE OF BIRTH<br><b>2-20-1917</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 10. AGE (in years lost birthday) <b>55</b>                                                                                                                  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Marion County, Ohio</b>                                                                                                                                   |  |                                                                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 13. FATHER'S NAME<br><b>Neal Houk</b>                                                                                                                       |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>                                                                                              |  |                                                                     |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Gladys Wood</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WWII</b>                                  |  | 17. SOCIAL SECURITY NO.<br><b>282-14-2181</b>                                                                                                                                                             |  | 18. INFORMANT<br><b>Boyd Funeral Home Marion Ohio</b>               |  |
| 19. CAUSE OF DEATH<br><b>E816.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Craniocerebral Injury</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>43302</b>                                                                                                                                              |  |                                                                     |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                          |  |                                                                     |  |
| 21. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                           |  |                                                                     |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street (5)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |  | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?<br><b>Southbound ramp from 695 - W. to I-83-238 S. of I-695 overpass</b>                                                         |  |                                                                     |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)<br><b>8 18 1972 3:25P.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                         |  |                                                                     |  |
| 22F. HOW DID INJURY OCCUR?<br><b>Driver of vehicle which ran off road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  | 23.                                                                                                                                                                                                       |  |                                                                     |  |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  |                                                                                                                                                                                                           |  |                                                                     |  |
| ACTUAL SIGNATURE<br><b>W P Mulloy</b><br>EXAMINER'S NAME (Type)<br><b>William P. Mulloy, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>8-20-72</b> |  |                                                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Crementation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 24B. DATE<br><b>9-12-72</b>                                                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Greenmount</b>                                                                                                                                                   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 13 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><b>Sidney Johnson</b>                                                                                                             |  | 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., Md. 21212</b>                                                                                        |  |                                                                     |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

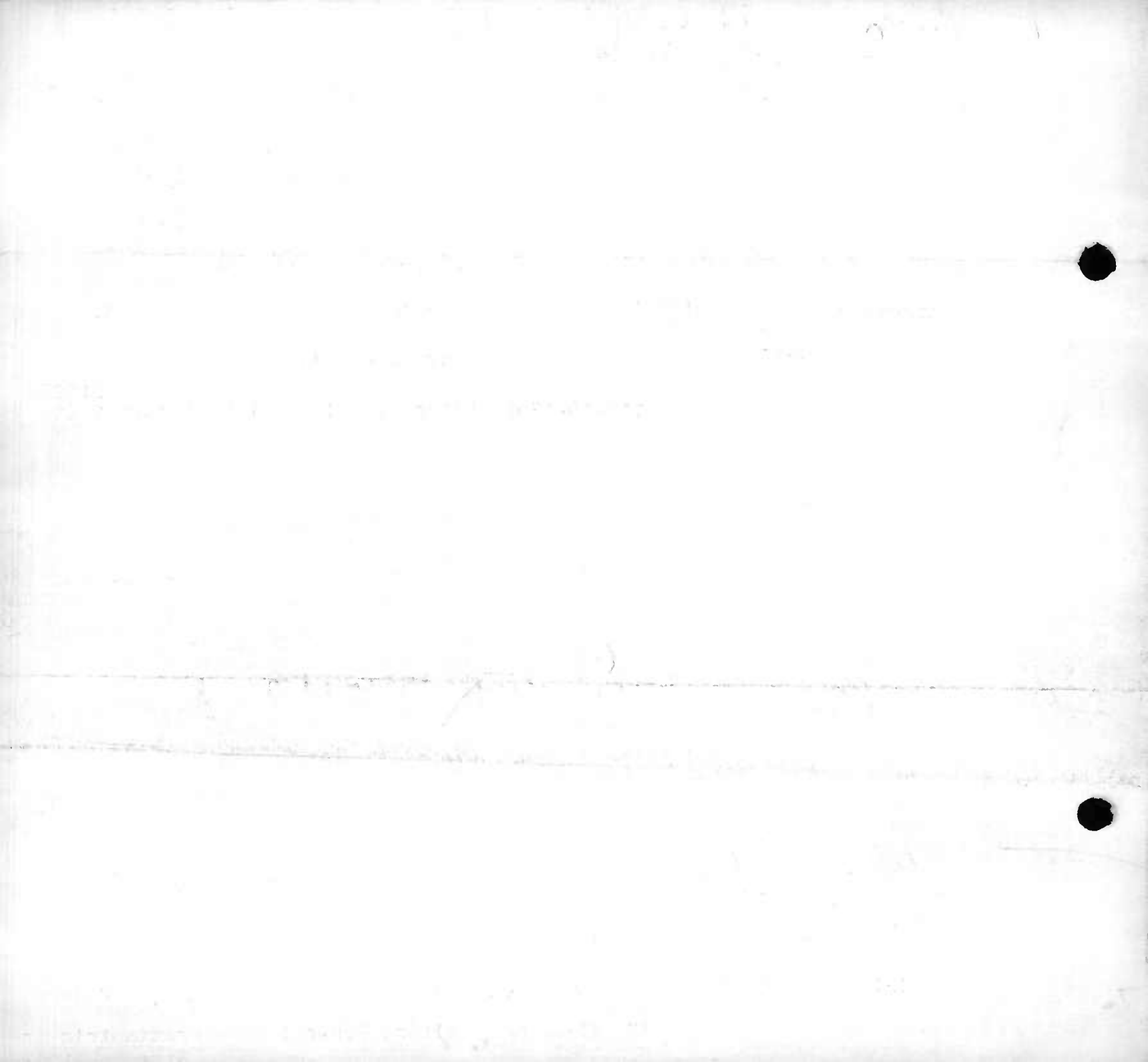
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                                                                            |                                                                                               |                                                              |                                                                      |                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------|
| W-600                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 72 08799                                                                                                                                                    |                                                                                                                                                                            | BALTIMORE CITY HEALTH DEPARTMENT                                                              |                                                              | 72 08799                                                             |                                            |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                            | REG. NO.                                                                                      |                                                              |                                                                      |                                            |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Hartley C. Weer</i>                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                                            | 2. DATE AND HOUR OF DEATH<br><i>September 9, 1972 8:15 A.M.</i>                               |                                                              |                                                                      |                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                                                            | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)         |                                                              |                                                                      |                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>00</i>                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                                                            | A. STATE<br><i>Maryland</i>                                                                   |                                                              |                                                                      |                                            |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>4544 North Charles Street</i>                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                                                                                                                                            | B. COUNTY<br><i>2711</i>                                                                      |                                                              | C. CITY OR TOWN<br><i>Baltimore</i>                                  |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                                                                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                              | E. STREET AND NUMBER<br><i>4544 North Charles Street</i>             |                                            |
| 5. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br><i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Nov. 6, 1892</i>                                                                                                                                    | 9. AGE (in years last birthday)<br><i>79</i>                                                  | If Under 1 Yr. Months                                        | If Under 24 Hrs. Days                                                | If Under 24 Hrs. Hours                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Book-keeper</i>                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>C.H. Lear Furniture</i>                                                                                                            |                                                                                               | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i> |                                                                      | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |
| 13. FATHER'S NAME<br><i>James E. Weer</i>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><i>Minta Copper</i>                                                                                                                            |                                                                                               |                                                              |                                                                      |                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no none</i>                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><i>215-03-1021</i>                                                                                                                              |                                                                                               | 17. INFORMANT<br><i>Family records</i>                       |                                                                      |                                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><i>205.01</i><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         |                                                                                                                                                             | CAUSE OF DEATH<br><i>Myelo-monocyte Leukemia - Gout</i><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |                                                                                               |                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 months plus</i> |                                            |
| 19A. DATE OF OPERATION<br><i>9-12-72</i>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>ENTOMBMENT</i>                                                                                       |                                                                                                                                                                            | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                                        |                                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                              |                                                                      |                                            |
| 21D. TIME OF INJURY (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                            | 21F. HOW DID INJURY OCCUR?                                                                    |                                                              |                                                                      |                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <i>June 6</i> 19 <i>72</i> to <i>September 9</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>September 5</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                         |                         |                                                                                                                                                             |                                                                                                                                                                            |                                                                                               |                                                              |                                                                      |                                            |
| 23A. SIGNATURE<br><i>W. Grafton Hersperger</i>                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                                                                                                                            | 23B. DATE SIGNED<br><i>September 11, 1972</i>                                                 |                                                              | 23C. PHYSICIAN'S NAME (Type)<br><i>W. Grafton Hersperger, M.D.</i>   |                                            |
| 23D. ADDRESS<br><i>214 Medical Arts Building</i>                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                                                                                            | 23E. FUNERAL DIRECTOR<br><i>John Barnes Sons</i>                                              |                                                              |                                                                      |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Entombment</i>                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 24B. DATE<br><i>9-12-72</i>                                                                                                                                 |                                                                                                                                                                            | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park Cemetery</i>                           |                                                              | 24D. LOCATION<br><i>Woodlawn Balto. Co. Md.</i>                      |                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 13 1972</i>                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 25B. NAME OF REGISTRAR<br><i>John Barnes Sons</i>                                                                                                           |                                                                                                                                                                            | 25C. FUNERAL DIRECTOR<br><i>Towson Md.</i>                                                    |                                                              |                                                                      |                                            |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

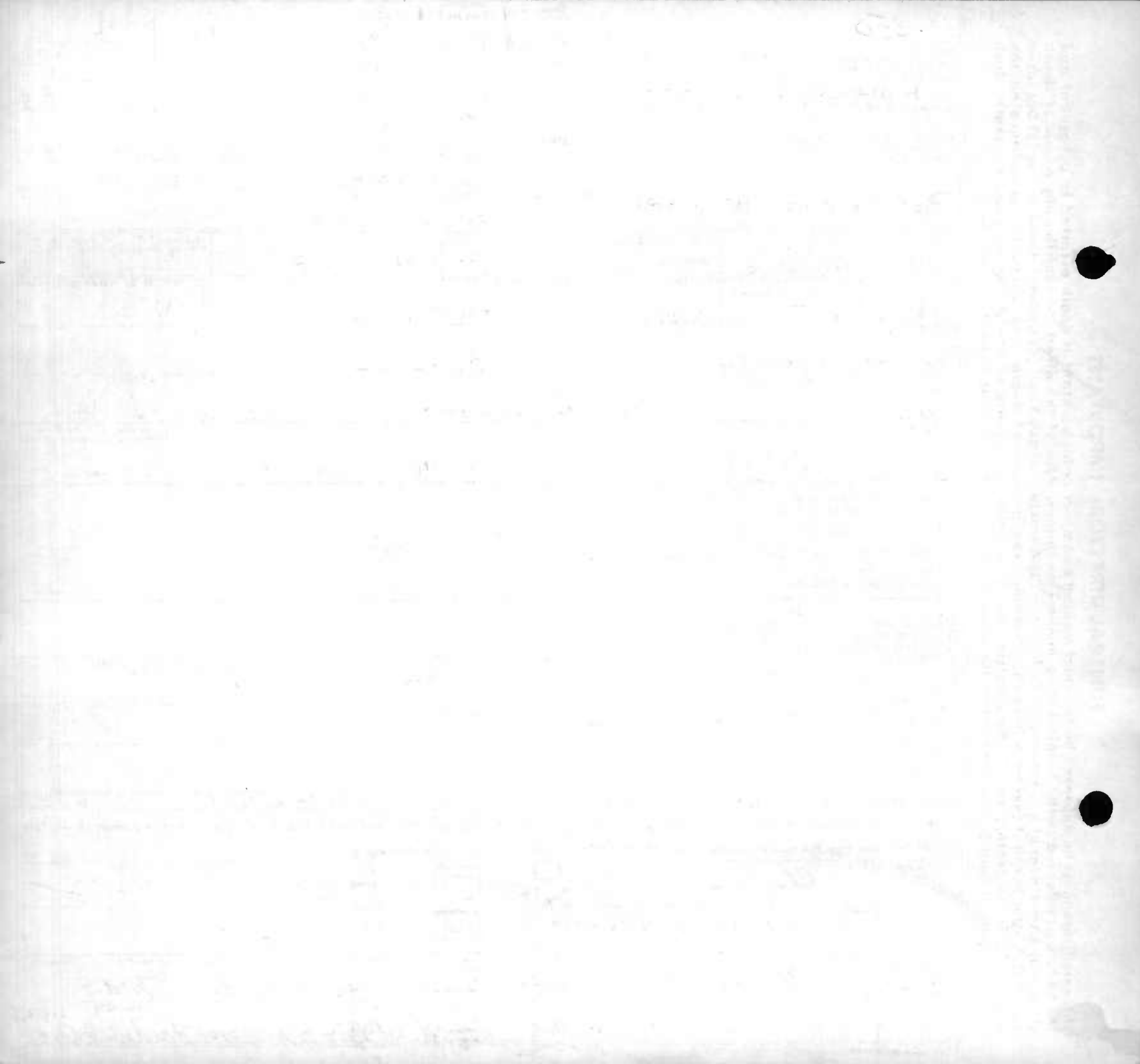
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                          |                                 | REG. NO. <u>72 08800</u>                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------|
| M-520 <u>Delva P. Minnick</u> <u>72 08800</u>                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                          |                                 | STATE OF MARYLAND - DEPT. OF HEALTH                                             |
| BIRTH NO. <u>72 08800</u>                                                                                                                                                                                                                                                                                            |                  | 1. NAME OF DECEASED (Type or Print) <u>University Hospital</u>                                                                                           |                                 |                                                                                 |
| 2. DATE AND HOUR OF DEATH <u>9/9/72</u> <u>15:00 P.M.</u>                                                                                                                                                                                                                                                            |                  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                   |                                 |                                                                                 |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>38</u>                                                                                                                                                                                                                                                                       |                  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                     |                                 |                                                                                 |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                                                                                                                                                                |                  | A. STATE <u>Baltimore</u> B. COUNTY <u>Maryland</u>                                                                                                      |                                 |                                                                                 |
| C. CITY OR TOWN <u>Baltimore</u>                                                                                                                                                                                                                                                                                     |                  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |                                 |                                                                                 |
| E. STREET AND NUMBER <u>1253 James St.</u>                                                                                                                                                                                                                                                                           |                  | <u>Baltimore Md 21223</u>                                                                                                                                |                                 |                                                                                 |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                      | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/24/02</u> | 9. AGE (In years last birthday) <u>70</u> 70                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>                                                                                                                                                                                                        |                  | 10B. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>                                                                                                        |                                 | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                       |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                                                                                                                                                                                                           |                  | 13. FATHER'S NAME <u>Joseph Recher</u>                                                                                                                   |                                 |                                                                                 |
| 14. MOTHER'S MAIDEN NAME <u>Mary Jane Wilson</u>                                                                                                                                                                                                                                                                     |                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>                                       |                                 |                                                                                 |
| 16. SOCIAL SECURITY NO. <u>218-18-1707</u>                                                                                                                                                                                                                                                                           |                  | 17. INFORMANT <u>Walter R. Mullins</u> ADDRESS <u>1125 Sargeant St.</u>                                                                                  |                                 |                                                                                 |
| 18. <u>593.21</u>                                                                                                                                                                                                                                                                                                    |                  | CAUSE OF DEATH                                                                                                                                           |                                 |                                                                                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                       |                  | (A) IMMEDIATE CAUSE <u>Cardiac arrest</u>                                                                                                                |                                 |                                                                                 |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                         |                  | DUE TO, OR AS A CONSEQUENCE OF: <u>massive pulmonary edema, CHF</u>                                                                                      |                                 |                                                                                 |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                    |                  | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Renal failure, peritonitis, Dehydration</u>                                                                       |                                 |                                                                                 |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                            |                  | (C) <u>hypertension (abdominal), bowel rupture</u>                                                                                                       |                                 |                                                                                 |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                     |                  | 19A. DATE OF OPERATION <u>9/7/72</u>                                                                                                                     |                                 |                                                                                 |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Dehydration, tracheostomy</u>                                                                                                                                                                                                                                    |                  | 20A. AUTOPSY? (Yes or No)                                                                                                                                |                                 | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)        |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                            |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                 | 21F. HOW DID INJURY OCCUR?                                                      |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/7/72</u> to <u>9/9/72</u> that (I) (we) last saw the deceased alive on <u>9/9/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                          |                                 |                                                                                 |
| 23A. SIGNATURE <u>Michael F. Graham</u>                                                                                                                                                                                                                                                                              |                  | 23B. DATE SIGNED <u>9/9/72</u>                                                                                                                           |                                 | 23C. PHYSICIAN'S NAME (Type) <u>Michael F. Graham</u>                           |
| 23D. ADDRESS <u>University Hospital</u>                                                                                                                                                                                                                                                                              |                  | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                   |                                 |                                                                                 |
| 24B. DATE <u>9/13/72</u>                                                                                                                                                                                                                                                                                             |                  | 24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>                                                                                           |                                 | 24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Maryland</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 13 1972</u>                                                                                                                                                                                                                                                                   |                  | 25B. NAME OF REGISTRAR <u>Walters</u>                                                                                                                    |                                 | 25C. FUNERAL DIRECTOR <u>Pratt &amp; Stricker</u>                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                  |  |                                                                                          |  | REG. NO. 72 08801                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| C-350 72 08801                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | STATE OF MARYLAND-DMH                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                            |  | 2. DATE AND HOUR OF DEATH                                                                |  |                                                                                       |  |
| Armando B. Cayetano                                                                                                                                                                                                                                                                               |  | 9-12-72                                                                                  |  | 5 <sup>20</sup> A.M.                                                                  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                            |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |  |                                                                                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                      |  | A. STATE B. COUNTY                                                                       |  |                                                                                       |  |
| Bon Secours Hospital                                                                                                                                                                                                                                                                              |  | Md. 1902                                                                                 |  |                                                                                       |  |
| 5. SEX                                                                                                                                                                                                                                                                                            |  | 6. RACE                                                                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| M                                                                                                                                                                                                                                                                                                 |  | Phillipine                                                                               |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                       |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 8. DATE OF BIRTH                                                                      |  |
| Machinist                                                                                                                                                                                                                                                                                         |  | Kopper's                                                                                 |  | 8-10-41                                                                               |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                 |  | 14. MOTHER'S MAIDEN NAME                                                                 |  | 9. AGE (In years last birthday)                                                       |  |
| Benito Cayetano                                                                                                                                                                                                                                                                                   |  | Bautista                                                                                 |  | 31                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                          |  | 16. SOCIAL SECURITY NO.                                                                  |  | 11. BIRTHPLACE (State or foreign country)                                             |  |
| yes                                                                                                                                                                                                                                                                                               |  | 549-64-5328                                                                              |  | Phillipines                                                                           |  |
| 18. 796.0 I                                                                                                                                                                                                                                                                                       |  | CAUSE OF DEATH                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?                                                          |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                    |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  | U.S.                                                                                  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                      |  | ABUTE MYOCARDIAL INFARCTION OR CVA                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                 |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  | 6 DAYS                                                                                |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                         |  | (C) _____                                                                                |  |                                                                                       |  |
| II                                                                                                                                                                                                                                                                                                |  |                                                                                          |  |                                                                                       |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                  |  |                                                                                          |  |                                                                                       |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                             |  |
| 2                                                                                                                                                                                                                                                                                                 |  |                                                                                          |  | Yes                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
|                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | Yes                                                                                   |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                            |  |
|                                                                                                                                                                                                                                                                                                   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/6/72 to 9/12/72 that (I) (we) last saw the deceased alive on 9/14/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                                       |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                    |  | 23B. DATE SIGNED                                                                         |  |                                                                                       |  |
| Chamber                                                                                                                                                                                                                                                                                           |  | 9/12/72                                                                                  |  |                                                                                       |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                      |  | 23D. ADDRESS                                                                             |  |                                                                                       |  |
| CHAIHAN UNGBHAKORN, M.D.                                                                                                                                                                                                                                                                          |  | BON SECOURS HOSPITAL                                                                     |  |                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                          |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY                                                    |  |
| Burial                                                                                                                                                                                                                                                                                            |  | 9/15/72                                                                                  |  | Crest Lawn Cem.                                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                 |  |
| SEP 13 1972                                                                                                                                                                                                                                                                                       |  | Dionysio                                                                                 |  | Sho. S. Schwartz, Inc. 2101 Frederick Ave.                                            |  |





BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)MARCELLUS  
VICTOR A/ CHRYSTAL2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1800 N. Charles Street, apt. 73A

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

September 12, 1972 11:20 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1205

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7/20/1892

10. AGE (In years  
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1800 N. Charles Street, apt. 73A

11. BIRTHPLACE (State or foreign country)

Frederick, Md.

12. CITIZEN OF

WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Victor M. Chrystal

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

Insurance

15. MOTHER'S MAIDEN NAME

Mary Elizabeth Donald

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

17. SOCIAL  
SECURITY NO.

215-07-8293

18. INFORMANT

Nephew:

Donald Ratcliffe, 7318 Brightside Rd.

ADDRESS Ruxton, Md.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy  
M.D.CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/12/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9/14/72

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

21201

STEWART &amp; MOWEN CO. 108 W. North Ave.

72-1000

WATSON

1000

1000

1000

1000

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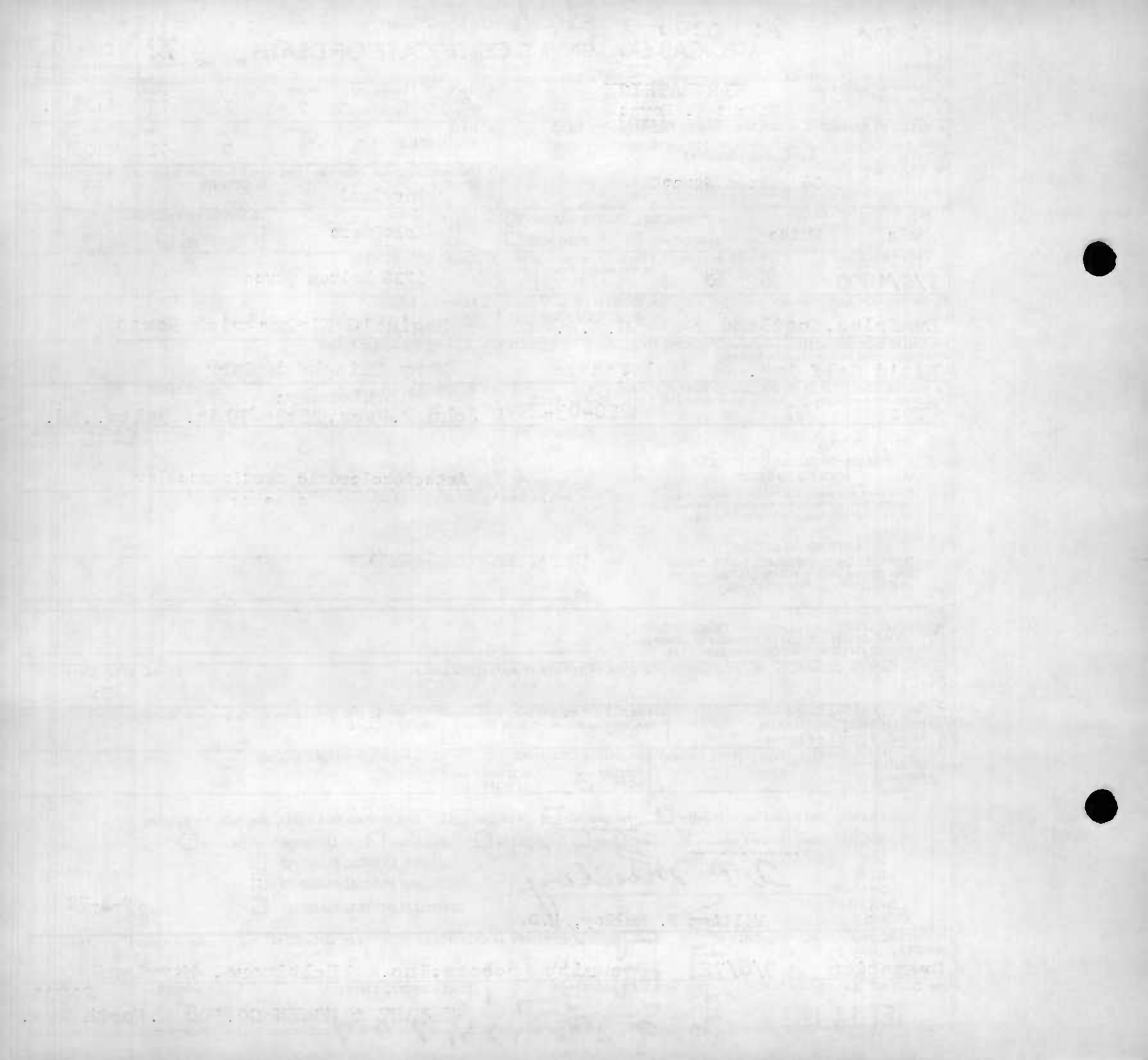
1000

STATE OF MARYLAND - DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. 72 08803 REG. NO. 72 08803

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>KIRKPATRICK</b><br><b>Robert K. Howat</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>9 7 72 1:35 P.</b>                         |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 1734 Bolton Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>9 7 72 1:35 P.</b>                                                                                                  |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7. RACE<br><b>White</b>                                                                                                                                                  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                      |  |
| 9. DATE OF BIRTH<br><b>1/9/1890</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                            |  |
| 10. AGE (In years last birthday)<br><b>82</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | E. STREET AND NUMBER<br><b>1734 Bolton Street</b>                                                                                                                        |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Dumfries, Scotland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. CITIZEN OF<br><b>U.S.A.</b>                                                                                                                                          |  |
| 13. FATHER'S NAME<br><b>Reginald Kirkpatrick Howat</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1401</b>                                 |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret'd Self Emp.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>                                                                                                                  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Mary Elizabeth Carr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WWI</b>                                                |  |
| 17. SOCIAL SECURITY NO.<br><b>220-03-2976</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 18. INFORMANT<br><b>Attorney: John P. Paca, Title Bldg., Balto., Md.</b>                                                                                                 |  |
| 19. CAUSE OF DEATH<br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease</b><br><b>DUE TO, OR AS A CONSEQUENCE OF: disease</b><br><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C)</b><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |
| 21. AUTOPSY? (Yes or No)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                          |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                 |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22D. TIME OF INJURY (Approx.)                                                                                                                                            |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                               |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                          |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>William P. Mulloy, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br><b>9-8-72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><b>9/8/72</b>                                                                                                                                               |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Security Process, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br><b>Sidney Lytherton</b>                                                                                                                        |  |
| 25C. FUNERAL DIRECTOR<br><b>STEWART &amp; MOWEN CO.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25D. ADDRESS<br><b>21201 108 W. North Ave.</b>                                                                                                                           |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                        |         |                                                                                          |                  | 72 08804                                                                              |                            | REG. NO.                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                               |         |                                                                                          |                  | 72 08804                                                                              |                            |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                  |         |                                                                                          |                  | 2. DATE AND HOUR OF DEATH                                                             |                            |                                                                      |  |
| Frederick W. YAHDE                                                                                                                                                                                                                                                                                      |         |                                                                                          |                  | 9-12-72 12:45 PM                                                                      |                            |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                  |         |                                                                                          |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                            |                                                                      |  |
|                                                                                                                                                                                                                                                                                                         |         |                                                                                          |                  | A. STATE B. COUNTY                                                                    |                            |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)                                                                                                                                                                                               |         |                                                                                          |                  | C. CITY OR TOWN                                                                       |                            | D. INSIDE CITY LIMITS?                                               |  |
|                                                                                                                                                                                                                                                                                                         |         |                                                                                          |                  | BALTO                                                                                 |                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| CHURCH HOME & HOSP 1 BALTO, Md.                                                                                                                                                                                                                                                                         |         |                                                                                          |                  | E. STREET AND NUMBER                                                                  |                            |                                                                      |  |
| 35                                                                                                                                                                                                                                                                                                      |         |                                                                                          |                  | Md. 2610                                                                              |                            |                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                  | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                                       | If Under 1 Yr. Months Days |                                                                      |  |
| M                                                                                                                                                                                                                                                                                                       | W       | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 09-04-96         | 76                                                                                    |                            |                                                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                             |         |                                                                                          |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                     |                            | 11. BIRTHPLACE (State or foreign country)                            |  |
| CABINET MAKER                                                                                                                                                                                                                                                                                           |         |                                                                                          |                  | Funerary                                                                              |                            | MARYLAND                                                             |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | 14. MOTHER'S MAIDEN NAME                                                              |                            |                                                                      |  |
| HERMAN YAHDE                                                                                                                                                                                                                                                                                            |         |                                                                                          |                  | Unknown                                                                               |                            |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                |         |                                                                                          |                  | 16. SOCIAL SECURITY NO.                                                               |                            | 17. INFORMANT ADDRESS                                                |  |
| No                                                                                                                                                                                                                                                                                                      |         |                                                                                          |                  | 215-10-1077                                                                           |                            | HOSPITAL RECORDS                                                     |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                      |         |                                                                                          |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                            |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                            |         |                                                                                          |                  | 1 hour.                                                                               |                            |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | weeks                                                                                 |                            |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                               |         |                                                                                          |                  | years                                                                                 |                            |                                                                      |  |
| II                                                                                                                                                                                                                                                                                                      |         |                                                                                          |                  |                                                                                       |                            |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                        |         |                                                                                          |                  |                                                                                       |                            |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                             |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| None                                                                                                                                                                                                                                                                                                    |         |                                                                                          |                  | No                                                                                    |                            |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                            |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                           |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                                            |                            |                                                                      |  |
| NONE                                                                                                                                                                                                                                                                                                    |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |                                                                                       |                            |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8-24-72 to 9-12-72 that (I) (we) last saw the deceased alive on Sept 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                                       |                            |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                          |         |                                                                                          |                  | 23B. DATE SIGNED                                                                      |                            |                                                                      |  |
| Bernard Yukna MD                                                                                                                                                                                                                                                                                        |         |                                                                                          |                  | Sept 12/1972                                                                          |                            |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                            |         |                                                                                          |                  | 23D. ADDRESS                                                                          |                            |                                                                      |  |
| BERNARD YUKNA                                                                                                                                                                                                                                                                                           |         |                                                                                          |                  | CHURCH HOME & HOSP.                                                                   |                            |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                |         | 24B. DATE                                                                                |                  | 24C. NAME OF CEMETERY or CREMATORY                                                    |                            | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                  |         | 9/15/72                                                                                  |                  | Oak Lawn Cemetery                                                                     |                            | Eastern Ave Balto Md                                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                         |         | 25B. NAME OF REGISTRAR                                                                   |                  | 25C. FUNERAL DIRECTOR                                                                 |                            | ADDRESS                                                              |  |
| SEP 14 1972                                                                                                                                                                                                                                                                                             |         | Sidney Johnston                                                                          |                  | J. J. Miller INC                                                                      |                            | 3019 E. Monument St                                                  |  |



G-420

72 08805

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08805

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) DOROTHY GILLIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>550 McMechen Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>September 12, 1972 9:05 A. M.                            |  |
| 6. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7. RACE<br>Negro                                                                                           |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | C. CITY OR TOWN<br>Baltimore                                                                               |  |
| 9. DATE OF BIRTH<br>3-6-22                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10. AGE (In years last birthday)<br>50                                                                     |  |
| 11. BIRTHPLACE (State or foreign country)<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                       |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                          |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.<br>214-14-0018                                                                     |  |
| 15. MOTHER'S MAIDEN NAME<br>Maggie Commadore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 18. INFORMANT ADDRESS                                                                                      |  |
| 19. 412.41<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                     |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                        |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22D. TIME OF INJURY (Approx.)                                                                              |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 22F. HOW DID INJURY OCCUR?                                                                                 |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: [Signature] Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 9/12/72 |  |                                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br>9-16-72                                                                                       |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Mt Calvary Cem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md.                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 14 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR<br>[Signature]                                                                      |  |
| 25C. FUNERAL DIRECTOR<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS<br>2700 Edmondson Ave                                                                              |  |



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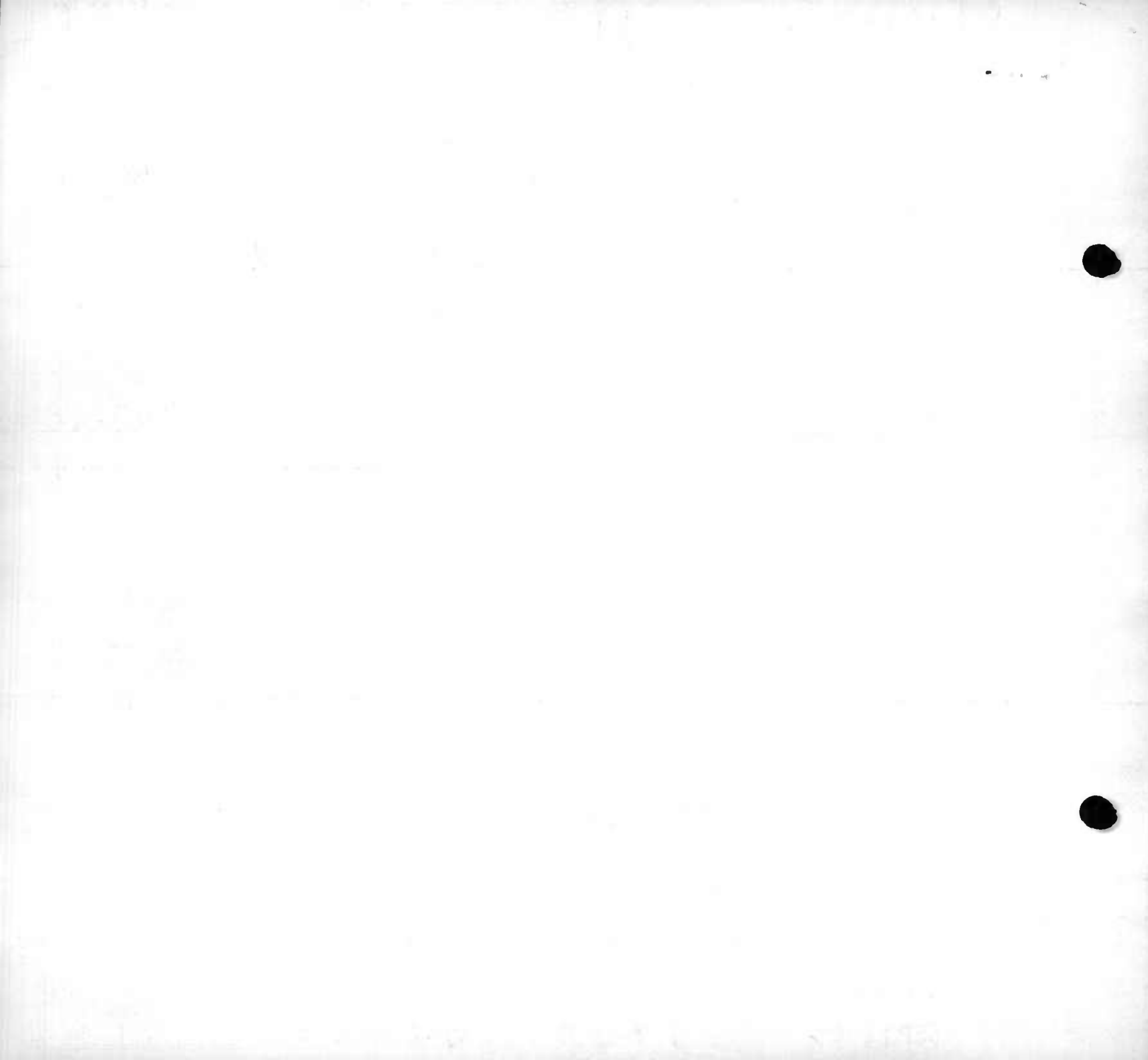
11/11/11



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                          |  | 72 08806                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>W-630</b><br><b>BIRTH NO.</b> <i>Dist of Col. 72 08806</i>                                                                                                                                                                                                                                                                                                                                                               |  | <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                              |  | <b>REG. NO.</b><br><b>STATE OF MARYLAND-DHMH</b>                                                                                                                                        |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <i>JOHN RAYMOND WARD</i>                                                                                                                                                                                                                                                                                                                                                      |  | <b>2. DATE AND HOUR OF DEATH</b><br><i>9/10/72 11:54 A.M.</i>                                                                                                                                            |  |                                                                                                                                                                                         |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>                                                                                                                                                                                                                                                                                                                                                               |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MARYLAND</i> B. COUNTY <i>CHARLES COUNTY</i>                                                 |  |                                                                                                                                                                                         |
| <b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br><i>UNIV. OF MARYLAND HOSPITAL 38</i>                                                                                                                                                                                                                                                                                                                                         |  | <b>C. CITY OR TOWN</b><br><i>MT. VICTORIA</i>                                                                                                                                                            |  | <b>D. INSIDE CITY LIMITS?</b><br>YES <input type="checkbox"/> ? NO <input type="checkbox"/>                                                                                             |
| <b>5. SEX</b><br><i>M</i>                                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>6. RACE</b><br><i>W</i>                                                                                                                                                                               |  | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>—                                                                                                                                                                                                                                                                                                                     |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br>—                                                                                                                                                            |  | <b>8. DATE OF BIRTH</b><br><i>2-24-70</i>                                                                                                                                               |
| <b>13. FATHER'S NAME</b><br><i>Charles Arthur Ward</i>                                                                                                                                                                                                                                                                                                                                                                      |  | <b>14. MOTHER'S MAIDEN NAME</b><br><i>MARRION ANNETTE THOMPSON</i>                                                                                                                                       |  | <b>9. AGE</b> (In years last birthday) <i>2 1/2</i><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                        |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br>—                                                                                                                                                                                                                                                                                                        |  | <b>6. SOCIAL SECURITY NO.</b><br>—                                                                                                                                                                       |  | <b>17. INFORMANT</b><br><i>FATHER</i>                                                                                                                                                   |
| <b>18. 32019 I</b><br><b>CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                |  | <b>(A) IMMEDIATE CAUSE</b> <i>RESP. FAILURE</i><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) INCREASED INTRACRANIAL PRESS.</b><br><b>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) MENINGITIS</b> |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><i>3 DAYS</i><br><i>3 DAYS</i><br><i>3 DAYS</i>                                                                                  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                          |  |                                                                                                                                                                                         |
| <b>19A. DATE OF OPERATION</b><br><i>2</i>                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br>—                                                                                                                                             |  | <b>20A. AUTOPSY?</b> (Yes or No)<br><i>YES</i>                                                                                                                                          |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)<br>—                                                                                                                                                                                                                                                                                                                           |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>—                                                                                                     |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)<br>—                                                                                                    |
| <b>21D. TIME OF INJURY</b> (Approx.)<br>—                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> — Not While At Work <input type="checkbox"/>                                                                                       |  | <b>21F. HOW DID INJURY OCCUR?</b><br>—                                                                                                                                                  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>SEPT 8</i> <b>19</b> <i>72</i> <b>to</b> <i>SEPT 10</i> <b>19</b> <i>72</i><br><b>that (I) (we) last saw the deceased alive on</b> <i>SEPT 10</i> <b>19</b> <i>72</i> <b>and that (in my) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |  |                                                                                                                                                                                                          |  |                                                                                                                                                                                         |
| <b>23A. SIGNATURE</b><br><i>Carolyn A Cowles</i>                                                                                                                                                                                                                                                                                                                                                                            |  | <b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>                                                     |  | <b>23B. DATE SIGNED</b><br><i>9/10/72</i>                                                                                                                                               |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><i>CAROLYN A COWLES</i>                                                                                                                                                                                                                                                                                                                                                              |  | <b>23D. ADDRESS</b><br><i>UNIV. OF MD. HOSP. PEDIATRICS DEPT BALT, MD</i>                                                                                                                                |  |                                                                                                                                                                                         |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                            |  | <b>24B. DATE</b><br><i>9/13/72</i>                                                                                                                                                                       |  | <b>24C. NAME of CEMETERY or CREMATORY</b><br><i>Holy Ghost Cemetery</i>                                                                                                                 |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><i>Essex, Charles, Md.</i>                                                                                                                                                                                                                                                                                                                                          |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><i>SEP 14 1972</i>                                                                                                                                             |  |                                                                                                                                                                                         |
| <b>25B. NAME OF REGISTRAR</b><br><i>Sidney</i>                                                                                                                                                                                                                                                                                                                                                                              |  | <b>25C. FUNERAL DIRECTOR</b><br><i>HUNT Funeral Home</i>                                                                                                                                                 |  |                                                                                                                                                                                         |
| <b>25D. ADDRESS</b><br><i>Waldorf Md.</i>                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>VS 150-REV. 1/1/68</b>                                                                                                                                                                                |  |                                                                                                                                                                                         |



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BALTIMORE CITY HEALTH DEPARTMENT

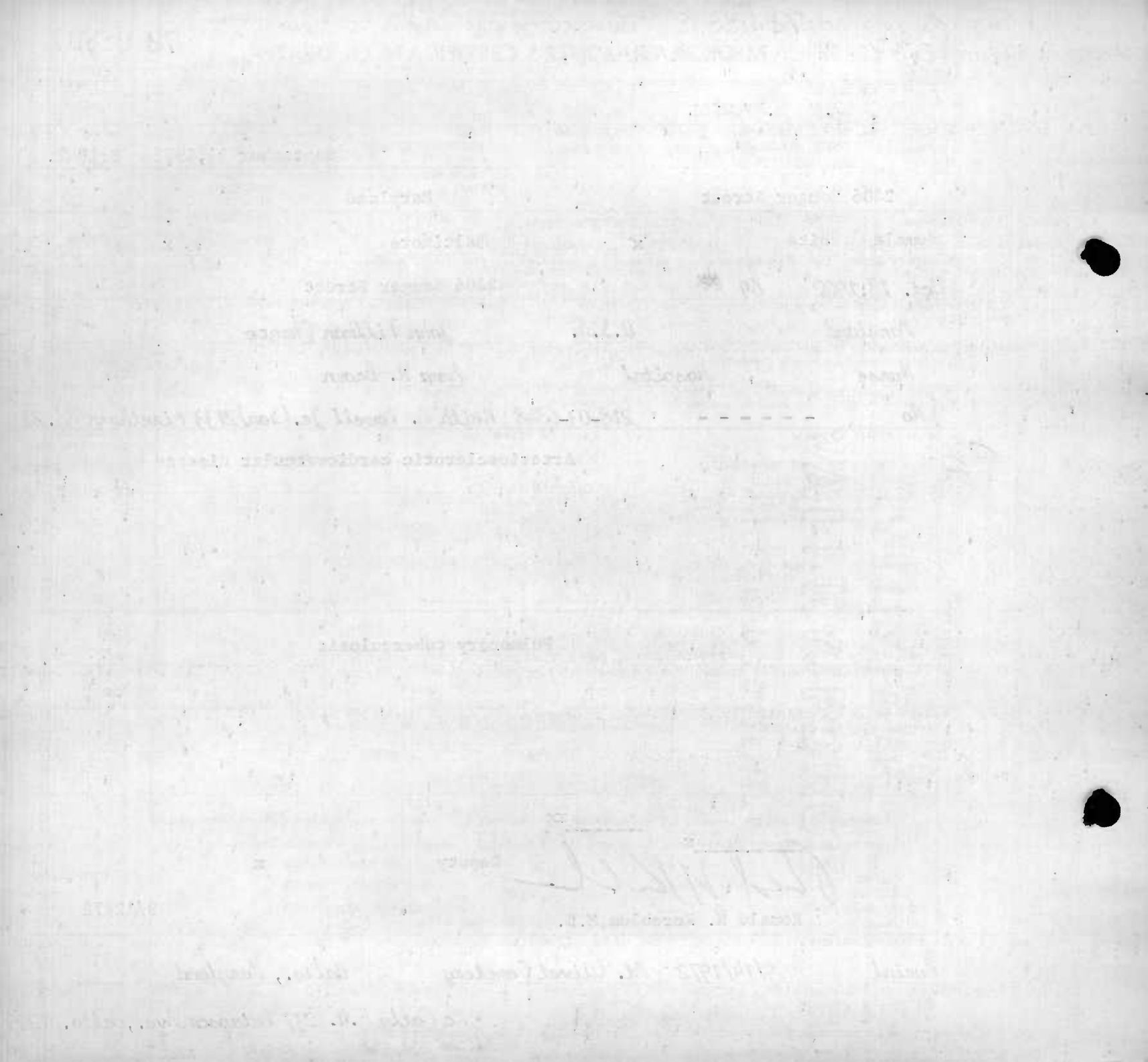
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08807

BIRTH NO. REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY M. POWELL</b>                                                                                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 2406 Banger Street</b>                                                                                                                                                                                                               |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 11, 1972 3:10 P. M.</b>                                                                      |  |
| 6. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 7. RACE<br><b>White</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                         |  |
| 9. DATE OF BIRTH<br><b>Oct. 18, 1902</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years last birthday) <b>69</b>                                                                                                                  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nurse</b>                                                                                                                                                                                                                                                                                                   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>                                                                                                        |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                          |  | 17. SOCIAL SECURITY NO.<br><b>218-03-6848</b>                                                                                                               |  |
| 18. INFORMANT<br><b>Keith M. Powell Jr. (Son)</b>                                                                                                                                                                                                                                                                                                                                                             |  | ADDRESS<br><b>2133 Firethorn Rd. 20</b>                                                                                                                     |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b>                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |  |
| II<br>Pulmonary tuberculosis                                                                                                                                                                                                                                                                                                                                                                                  |  | (C)                                                                                                                                                         |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                      |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                   |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                             |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum, M.D.</b>                                                                                                                                                                                                                                                                                                                                                           |  | DEPUTY CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                           |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>9/14/1972</b>                                                                                                                               |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Olivet Cemetery</b>                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Maryland</b>                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Sidney H. Hinton</b>                                                                                                           |  |
| 25C. FUNERAL DIRECTOR<br><b>McCully F.H.</b>                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS<br><b>237 Patapsco Ave., Balto. 21225</b>                                                                                                           |  |

VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |                                                 |                                                                                          |                                                             |                                                                                                                      |                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| BIRTH NO. <b>R-153</b>                                                                                                                                                                                                                                                                                                          |                     | 72 08808                                                                                                                                                    |                                                 | BALTIMORE CITY HEALTH DEPARTMENT                                                         |                                                             | REG. NO. <b>72 08808</b>                                                                                             |                                            |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY BOY Robinette, Edwin L., Jr.</b>                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |                                                 | 2. DATE AND HOUR OF DEATH<br><b>9-11-72</b>                                              |                                                             |                                                                                                                      |                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                             |                                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |                                                             |                                                                                                                      |                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University of Maryland Hospital</b>                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |                                                 | A. STATE <b>MD</b>                                                                       |                                                             |                                                                                                                      |                                            |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |                                                 | C. CITY OR TOWN<br><b>Balto</b>                                                          |                                                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |                                            |
| 38                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                                 | E. STREET AND NUMBER<br><b>425 W. 24th ST</b>                                            |                                                             |                                                                                                                      |                                            |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-8-72</b>               | 9. AGE (In years last birthday)<br><b>4 days</b>                                         | If Under 1 Yr. Months Days                                  | If Under 24 Hrs. Hours Min.                                                                                          |                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Newborn</b>                                                                                                                                                                                                                   |                     |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>---</b> |                                                                                          | 11. BIRTHPLACE (State or foreign country)<br><b>MD</b>      |                                                                                                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
| 13. FATHER'S NAME<br><b>Edwin Robinette</b>                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                             |                                                 | 14. MOTHER'S MAIDEN NAME<br><b>Etta Shaffer</b>                                          |                                                             |                                                                                                                      |                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                           |                     |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>None</b>          |                                                                                          | 17. INFORMANT<br><b>Edwin L. Robinette, 425 W. 24th St.</b> |                                                                                                                      |                                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>Cardio-respiratory arrest</b>                                                                  |                     |                                                                                                                                                             |                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b>                            |                                                             |                                                                                                                      |                                            |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Brain Hypoxia</b>                                                                                                                                                                          |                     |                                                                                                                                                             |                                                 | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Respiratory Distress</b>    |                                                             |                                                                                                                      |                                            |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Prolonged anoxia at birth</b>                                                                                                                                                            |                     |                                                                                                                                                             |                                                 | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>4 days</b>                                     |                                                             |                                                                                                                      |                                            |
| 19A. DATE OF OPERATION<br><b>None</b>                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |                                                 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>                          |                                                             | 20A. AUTOPSY? (Yes or No)<br><b>Accepted</b>                                                                         |                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                               |                     |                                                                                                                                                             |                                                 | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                                             | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                          |                                            |
| 21D. TIME OF INJURY (APPROX.)<br>1 (Month) 2 (Day) 3 (Year) 4 (Hour)                                                                                                                                                                                                                                                            |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                 | 21F. HOW DID INJURY OCCUR?                                                               |                                                             |                                                                                                                      |                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/8/72</b> 19 to <b>9/11/72</b> 19 that (I) (we) last saw the deceased alive on <b>9/11/72</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                             |                                                 |                                                                                          |                                                             |                                                                                                                      |                                            |
| 23A. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |                                                 | 23B. DATE SIGNED<br><b>9/11/72</b>                                                       |                                                             | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                            |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROGER Y. TAKLA</b>                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |                                                 | 23D. ADDRESS<br><b>Univ. of Md. Depart. of Pediatrics</b>                                |                                                             |                                                                                                                      |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                        |                     | 24B. DATE                                                                                                                                                   |                                                 | 24C. NAME OF CEMETERY OR CREMATORY                                                       |                                                             | 24D. LOCATION (City, town, or county) (State)                                                                        |                                            |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                                   |                     | <b>9/14/72</b>                                                                                                                                              |                                                 | <b>St. Marys Cemetery (Hamden)</b>                                                       |                                                             | <b>Baltimore, Maryland</b>                                                                                           |                                            |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                 |                     | 25B. NAME OF REGISTRAR                                                                                                                                      |                                                 | 25C. FUNERAL DIRECTOR                                                                    |                                                             | ADDRESS                                                                                                              |                                            |
| <b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                              |                     | <b>[Signature]</b>                                                                                                                                          |                                                 | <b>A. Alan Seitz, Jr.</b>                                                                |                                                             | <b>3818 Roland Ave.</b>                                                                                              |                                            |



STATE OF MARYLAND-DHMH  
72 08809 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 72 08809

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>EMORY CRUNKILTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                         |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>38 UNIVERSITY HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 9, 1972 7:25 P.</b> M.                                                              |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7. RACE<br><b>White</b>                                                                                                                            |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>CHESAPEAKE</b> 5600 |  |
| 9. DATE OF BIRTH<br><b>May 21, 1937</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10. AGE (In years lost birthday) <b>35</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                               |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                         |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck Driver</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 17. SOCIAL SECURITY NO.<br><b>216-30-7075</b>                                                                                                      |  |
| 13. FATHER'S NAME<br><b>Stanley L. Crunkilton Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br><b>Ruth Roberts</b>                                                                                                    |  |
| 18. INFORMANT<br><b>Mrs. Doris J. Crunkilton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS<br><b>Finksburg, Md.</b>                                                                                                                   |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>Bronchopneumonia and cerebral anoxia</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Multiple Injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>5812.1</b>                                                                                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                       |  |
| 20A. DATE OF OPERATION<br><b>22</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Street</b>                                          |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>State Rt. 97, north of Frizzeleberg, M.d.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br><b>8-26-72 3:26 A. m.</b>                                                             |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22F. HOW DID INJURY OCCUR?<br><b>Driver in truck-auto collision(head-on)</b>                                                                       |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>DATE SIGNED <b>9/10/72</b> |  |                                                                                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 24B. DATE<br><b>Sept. 13, 72</b>                                                                                                                   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Reisterstown Methodist</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24D. LOCATION (City, town, or county) (State)<br><b>Reisterstown, Md.</b>                                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br><b>Edney Johnson</b>                                                                                                     |  |
| 25C. FUNERAL DIRECTOR<br><b>Eline Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br><b>Reisterstown, Md. 21136</b>                                                                                                          |  |

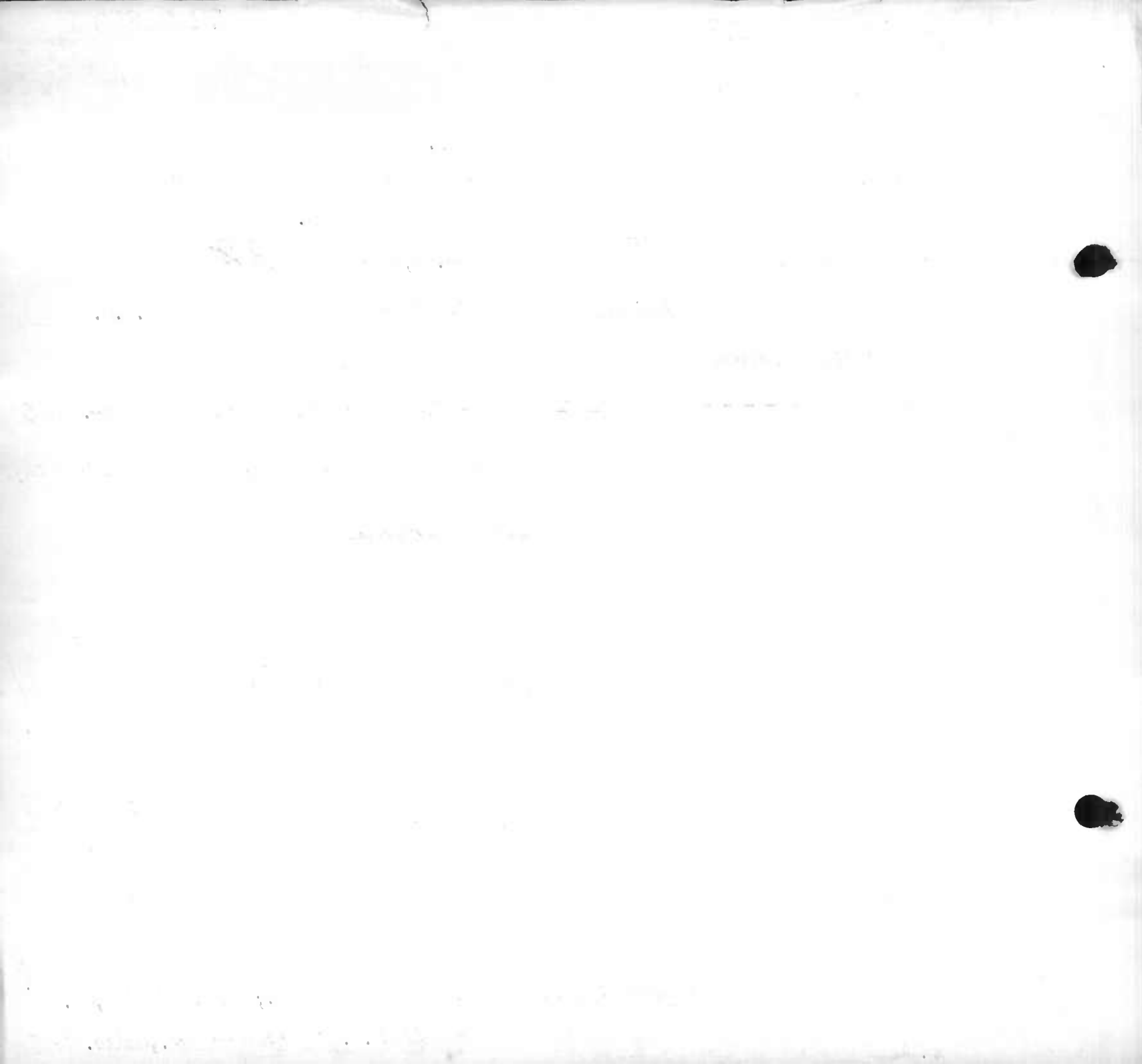




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

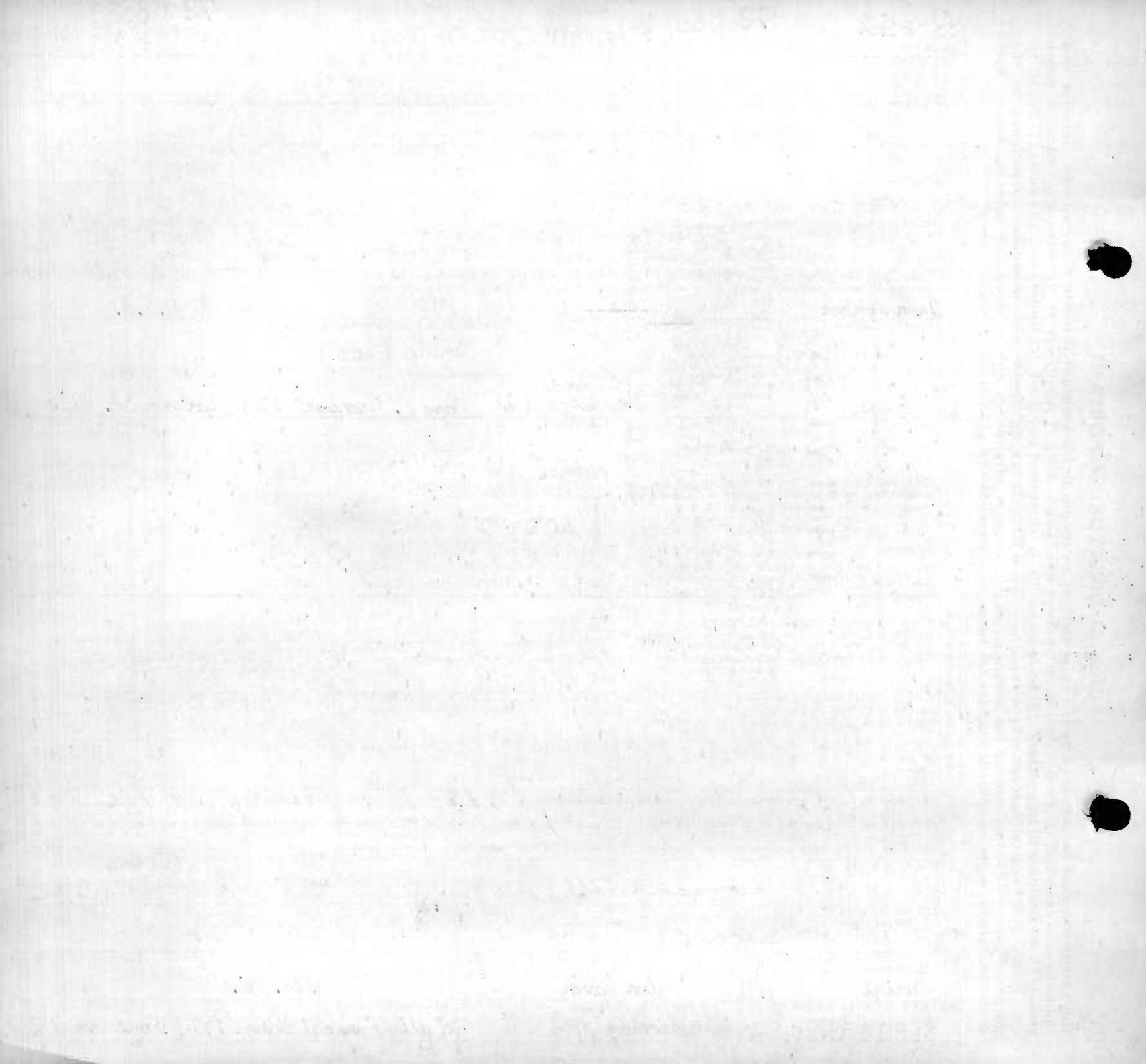
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                                                                                                                                                                                              |                                         | REG. NO. 72 08810                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------------------------------|
| BIRTH NO. S-415                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 72 08810                                                                                                                                                                                                                                                                                                                     |                                         | STATE OF MARYLAND-DEATH                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GEORGE SULLIVAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 2. DATE AND HOUR OF DEATH<br><b>9/11/72 8:10 P.M.</b>                                                                                                                                                                                                                                                                        |                                         |                                                                                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b><br><b>43</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>2544</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>4202 Audrey Ave.</b>      |                                         |                                                                                                     |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                  | 8. DATE OF BIRTH<br><b>Aug. 9, 1934</b> | 9. AGE (In years last birthday) <b>38</b><br>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>                                                                                                                                                                                                                                                                         |                                         | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                        |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 13. FATHER'S NAME<br><b>William Sullivan</b>                                                                                                                                                                                                                                                                                 |                                         |                                                                                                     |
| 14. MOTHER'S MAIDEN NAME<br><b>Lillian Norfolk</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                        |                                         |                                                                                                     |
| 16. SOCIAL SECURITY NO.<br><b>219-30-1247</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 17. INFORMANT ADDRESS<br><b>Myrtle Sullivan (Wife) 4202 Audrey Ave. 21225</b>                                                                                                                                                                                                                                                |                                         |                                                                                                     |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(A) IMMEDIATE CAUSE <del>PROBABLY SUBPULMONARY HEMATOMA</del><br>(B) <del>OLD TUBERCULOSIS</del><br>(C)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>ACUTE RENAL FAILURE</b> |                         |                                                                                                                                                                                                                                                                                                                              |                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4-5 DAYS</b><br><br><b>2 DAYS</b>                |
| 19A. DATE OF OPERATION<br><b>9/5</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                             |                                         | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                             |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                               |                                         |                                                                                                     |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                     |                                         |                                                                                                     |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                       |                                         |                                                                                                     |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 22. I certify that (I) (this hospital) attended the deceased from <b>9/5 1972</b> to <b>9/11 1972</b> that (I) (we) last saw the deceased alive on <b>9/11 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                         |                                                                                                     |
| 23A. SIGNATURE<br><b>Robert J. Bauer, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 23B. DATE SIGNED<br><b>9/11/72</b>                                                                                                                                                                                                                                                                                           |                                         | 23C. PHYSICIAN'S NAME (Type)<br><b>ROBERT J. BAUER, M.D.</b>                                        |
| 23D. ADDRESS<br><b>3061 S. HANOVER ST. BALT, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                    |                                         |                                                                                                     |
| 24B. DATE<br><b>9/15/1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 24C. NAME of CEMETERY or CREMATORY<br><b>Good Shepherd Cemetery</b>                                                                                                                                                                                                                                                          |                                         | 24D. LOCATION (City, town, or county) (State)<br><b>Howard Co.; Ellicott City, Md.</b>              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 25B. NAME OF REGISTRAR<br><b>Disney Whitson</b>                                                                                                                                                                                                                                                                              |                                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>McGubly F.H., 237 Patapsco Ave., Balto. 21225</b>               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

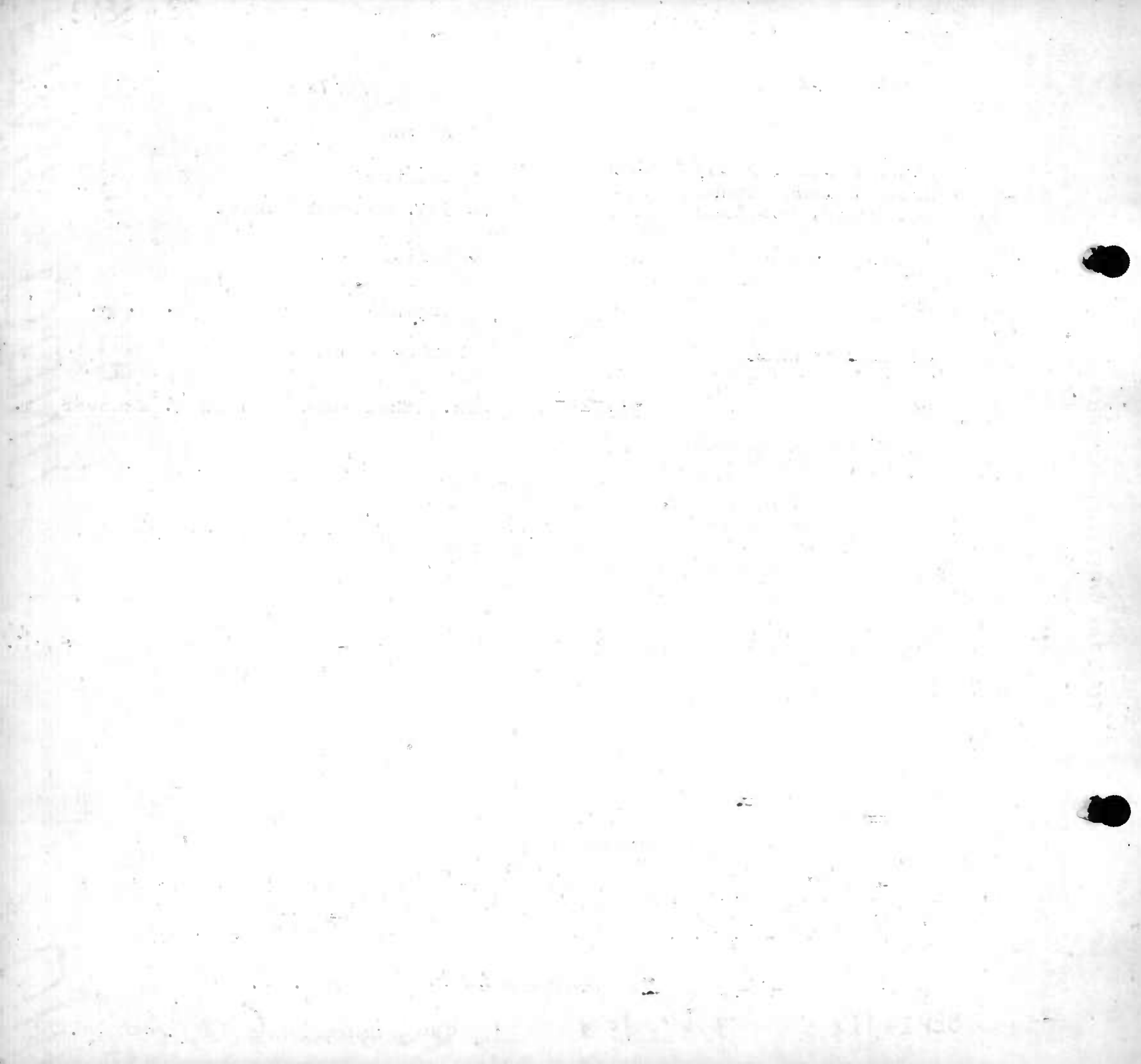
| BALTIMORE CITY HEALTH DEPARTMENT                                                                          |  |                                                                                                          |  | 72 08811                                                                                                                                                                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| G-652                                                                                                     |  |                                                                                                          |  | 72 08811                                                                                                                                                                                                                                                                                                        |  |
| BIRTH NO.                                                                                                 |  |                                                                                                          |  | REG. NO.                                                                                                                                                                                                                                                                                                        |  |
| 1. NAME OF DECEASED                                                                                       |  |                                                                                                          |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                                                                                                       |  |
| (Type or Print) <b>GRANGER ARTHUR</b>                                                                     |  |                                                                                                          |  | <b>9/12/1972</b> <span style="float: right;">h AM.</span>                                                                                                                                                                                                                                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                    |  |                                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                                                                                                                                                           |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |  |                                                                                                          |  | A. STATE B. COUNTY                                                                                                                                                                                                                                                                                              |  |
| <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>                                                                   |  |                                                                                                          |  | <b>MD</b>                                                                                                                                                                                                                                                                                                       |  |
| <b>43 BALTO, MD 21230</b>                                                                                 |  |                                                                                                          |  | <b>C. CITY OR TOWN D. INSIDE CITY LIMITS?</b>                                                                                                                                                                                                                                                                   |  |
| <b>1523 CLARKSON ST.</b>                                                                                  |  |                                                                                                          |  | <b>BALTO</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                |  |
| 5. SEX                                                                                                    |  | 6. RACE                                                                                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                           |  |
| <b>MALE</b>                                                                                               |  | <b>WHITE</b>                                                                                             |  | <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>                                                                                                                                                                                                                                       |  |
| 8. DATE OF BIRTH                                                                                          |  | 9. AGE (In years last birthday)                                                                          |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                      |  |
| <b>11/2/1897</b>                                                                                          |  | <b>74</b>                                                                                                |  | <b>Iron Worker</b>                                                                                                                                                                                                                                                                                              |  |
| 11. BIRTHPLACE (State or foreign country)                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?                                                                             |  | 13. FATHER'S NAME                                                                                                                                                                                                                                                                                               |  |
| <b>MD</b>                                                                                                 |  | <b>U.S.A.</b>                                                                                            |  | <b>SAM (DEC.)</b>                                                                                                                                                                                                                                                                                               |  |
| 14. MOTHER'S MAIDEN NAME                                                                                  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                         |  |
| <b>SADIE (DEC.)</b>                                                                                       |  | <b>UNKNOWN</b>                                                                                           |  | <b>219-05-0162 A</b>                                                                                                                                                                                                                                                                                            |  |
| 17. INFORMANT                                                                                             |  | 18. CAUSE OF DEATH                                                                                       |  | 19. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                       |  |
| <b>Mary E. Granger 1523 Clarkson St. Wife</b>                                                             |  | <b>4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                                             |  | <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                      |  |
| <b>CVA</b>                                                                                                |  | <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b>                                               |  | <b>19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                                                                                                                                  |  |
| <b>ACBUD</b>                                                                                              |  | <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>                                                               |  | <b>20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                                                                                                                                                                                                           |  |
| <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>                                                                |  | <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b>             |  | <b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>                                                                                                                                                                                                                 |  |
| <b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b>                           |  | <b>21D. TIME OF INJURY (APPROX.)</b>                                                                     |  | <b>21E. INJURY OCCURRED</b>                                                                                                                                                                                                                                                                                     |  |
| <b>21F. HOW DID INJURY OCCUR?</b>                                                                         |  | <b>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></b>                 |  | <b>22. I certify that (I) (this hospital) attended the deceased from 9/8/1972 to 9/12/1972, that (I) (we) last saw the deceased alive on 9/12/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |  |
| <b>23A. SIGNATURE</b>                                                                                     |  | <b>23B. DATE SIGNED</b>                                                                                  |  | <b>23C. PHYSICIAN'S NAME (Type)</b>                                                                                                                                                                                                                                                                             |  |
| <b>M. Kovacevic</b>                                                                                       |  | <b>9/12/1972</b>                                                                                         |  | <b>M. KOVACEVIC MD</b>                                                                                                                                                                                                                                                                                          |  |
| <b>23D. ADDRESS</b>                                                                                       |  | <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>                                                          |  | <b>24B. DATE</b>                                                                                                                                                                                                                                                                                                |  |
| <b>24C. NAME of CEMETERY or CREMATORY</b>                                                                 |  | <b>24D. LOCATION (City, town, or county) (State)</b>                                                     |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b>                                                                                                                                                                                                                                                                          |  |
| <b>25B. NAME OF REGISTRAR</b>                                                                             |  | <b>25C. FUNERAL DIRECTOR</b>                                                                             |  | <b>25D. ADDRESS</b>                                                                                                                                                                                                                                                                                             |  |
| <b>25E. DATE REC'D BY HEALTH DEPT.</b>                                                                    |  | <b>25F. NAME OF REGISTRAR</b>                                                                            |  | <b>25G. FUNERAL DIRECTOR</b>                                                                                                                                                                                                                                                                                    |  |
| <b>SEP 14 1972</b>                                                                                        |  | <b>Sidney H. Weston</b>                                                                                  |  | <b>McCully Funeral Home 130 E. Fort Ave 21230</b>                                                                                                                                                                                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

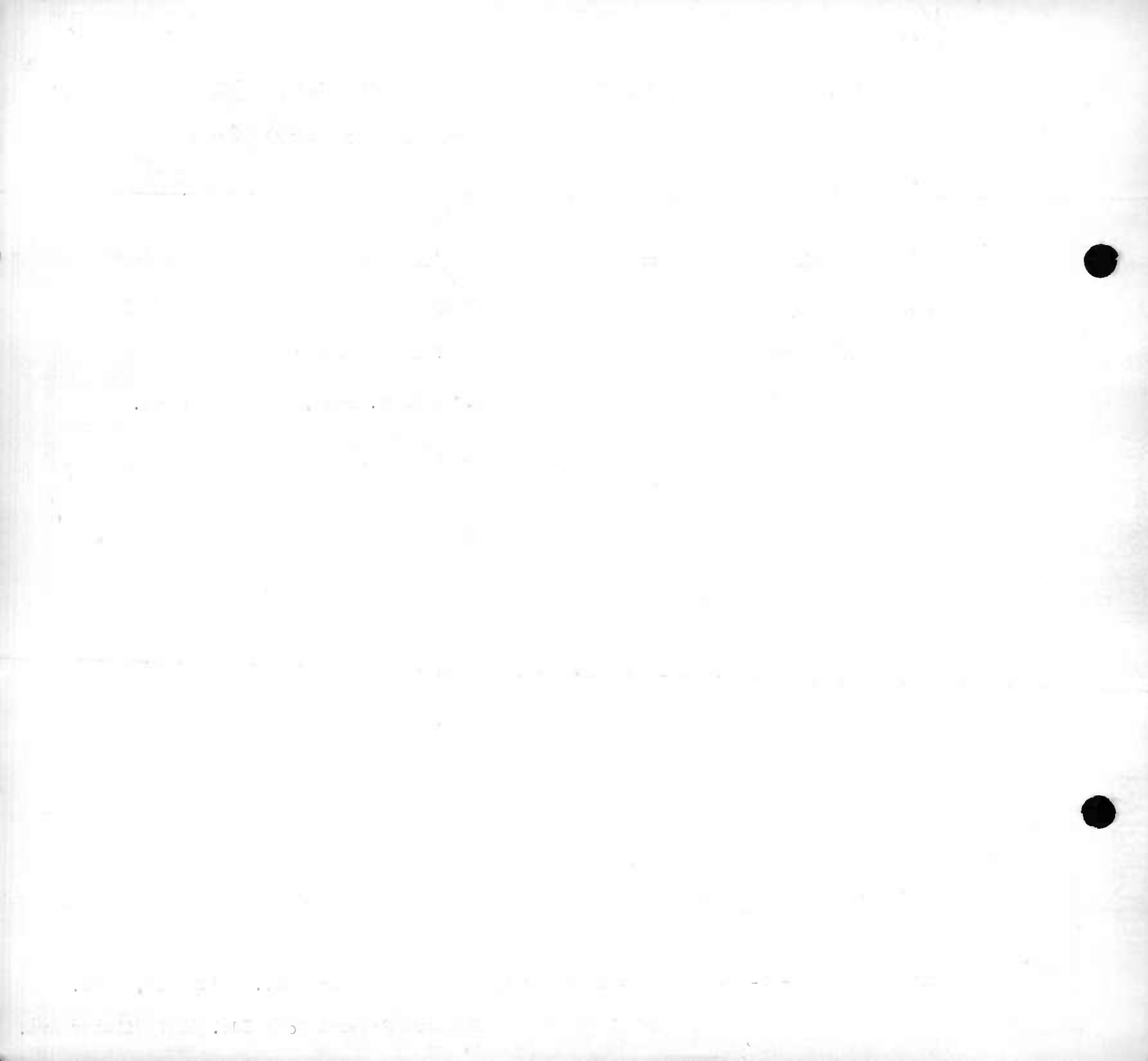
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                      | 72 08812                                                                                                                                                                                                                                                                                                                           |                                              | 72 08812                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                      | REG. NO.                                                                                                                                                                                                                                                                                                                           |                                              | STATE OF MARYLAND - DEPT.                                            |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mary Ingram</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                      | 2. DATE AND HOUR OF DEATH<br><b>9/8/72</b> <b>2:30 P. M.</b>                                                                                                                                                                                                                                                                       |                                              |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Caton Manor Nursing Center<br/>3330 Wilkens Avenue<br/>Baltimore, Maryland 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2301</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1425 S. Hanover Street</b> |                                              |                                                                      |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/22/1898</b> |                                                                                                                                                                                                                                                                                                                                    | 9. AGE (In years last birthday)<br><b>74</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.            |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>N/a</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>                                                                                                             |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                       |                                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                      |  |
| 13. FATHER'S NAME<br><b>William Kennard</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Martha Johnson</b>                                                                                                                                                                                                                                                                                  |                                              |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>n/a</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 16. SOCIAL SECURITY NO.<br><b>3188-09-2</b>                                                                                                                 |                                      | 17. INFORMANT<br><b>Mrs. Ethel Best</b>                                                                                                                                                                                                                                                                                            |                                              | ADDRESS<br><b>1425 S. Hanover St.</b>                                |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>191X I</b><br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive pneumonia 4 days</b><br>(B) <b>Malignant Brain Tumor</b><br>(C) <b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         |                                                                                                                                                             |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>                                                                                                                                                                                                                                                                      |                                              |                                                                      |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                      | 20A. AUTOPSY? (Yes or No) <b>No</b>                                                                                                                                                                                                                                                                                                |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                           |                                              |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                         |                                              |                                                                      |  |
| 22. I certify that (1) <del>the deceased</del> attended the deceased from <b>8/29/72</b> 19 to <b>9/8/72</b> 19, that (1) <del>the deceased</del> lost saw the deceased alive on <b>9/8/72</b> 19 and that in (my) <del>the</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>the deceased</del> (did not) view the body after death.                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                      |                                                                                                                                                                                                                                                                                                                                    |                                              |                                                                      |  |
| 23A. SIGNATURE<br><b>Cliff Ratliff, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                      | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                                                                                                                                                                                    |                                              | 23B. DATE SIGNED<br><b>9/11/72</b>                                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Cliff Ratliff, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                      | 23D. ADDRESS<br><b>5772 Westview Mall<br/>Baltimore, Maryland 21228</b>                                                                                                                                                                                                                                                            |                                              |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 24B. DATE<br><b>9-12-72</b>                                                                                                                                 |                                      | 24C. NAME OF CEMETERY or CREMATORY<br><b>Glen Haven Memorial Park</b>                                                                                                                                                                                                                                                              |                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 25B. NAME OF REGISTRAR<br><b>Andrew H. ...</b>                                                                                                              |                                      | 25C. FUNERAL DIRECTOR<br><b>McGulley Funeral Home</b>                                                                                                                                                                                                                                                                              |                                              | ADDRESS<br><b>130 E. Fort Ave. 21230</b>                             |  |



# FUNERAL DIRECTOR: IMPORTANT

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| K-613                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |              | 72 08813                                                                                                                                                    |                              | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                                           | 72 08813                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              |                                                                                                                                                             |                              | REG. NO.                                                                              |                                           |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |                              | 2. DATE AND HOUR OF DEATH                                                             |                                           |                                                                                               |  |
| MARIE C. KRAFT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                             |                              | 10 Sept 72 6 A.M.                                                                     |                                           |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                           |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>MONTEBELLO STATE HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                             |                              | A. STATE<br>1810 HARMAN AVE. 2553                                                     |                                           |                                                                                               |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |              |                                                                                                                                                             |                              | C. CITY OR TOWN<br>BALTO                                                              |                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |                              | E. STREET AND NUMBER<br>1810 HARMAN AVE                                               |                                           |                                                                                               |  |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. RACE<br>C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>10/22/04 | 9. AGE (in years last birthday)<br>67                                                 | 10. Under 1 Yr. Months: Days: Hours: Min. | 11. Under 24 Hrs. Min.                                                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                              | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                 |                                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                           |  |
| 13. FATHER'S NAME<br>Henry Clarke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                             |                              | 14. MOTHER'S MAIDEN NAME<br>Caroline Barline                                          |                                           |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              | 16. SOCIAL SECURITY NO.                                                                                                                                     |                              | 17. INFORMANT<br>Mr. Gerald M. Kraft, 7477 Rabon Ave.                                 |                                           | ADDRESS                                                                                       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>41221<br>BILATERAL INTRACEREBRAL Hemorrhage & hemiplegia<br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>W C U D<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>Osteoarthritis<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No)<br>NO<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br>21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>22. I certify that (I) (this hospital) attended the deceased from 9 Sept 1972 to 10 Sept 1972 that (I) (we) last saw the deceased alive on 10 Sept 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE<br>Joseph Sappington<br>23B. DATE SIGNED<br>10 Sept 72<br>23C. PHYSICIAN'S NAME (Type)<br>JOSEPH SAPPINGTON<br>23D. ADDRESS<br>UNIVERSITY of Md. Hosp.<br>24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial<br>24B. DATE<br>9-12-1972<br>24C. NAME OF CEMETERY or CREMATORY<br>Western Cemetery<br>24D. LOCATION<br>Edmondson Ave. Baltimore, Md.<br>25A. DATE REC'D BY HEALTH DEPT.<br>SEP 14 1972<br>25B. NAME OF REGISTRAR<br>25C. FUNERAL DIRECTOR<br>Hubbard Funeral Home INC. 4107 Wilkens Ave.<br>ADDRESS |              |                                                                                                                                                             |                              |                                                                                       |                                           |                                                                                               |  |





## CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND-DEME

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SCHRECK, CHARLES

2. DATE AND HOUR OF DEATH

SEPTEMBER 11, 1972 8:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

4202 HOLLINS FERRY ROAD - 21227

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

01 24 85

9. AGE (In years  
last birthday)

87

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PIPEFITTER

10B. KIND OF BUSINESS OR INDUSTRY

STEAMFITTERS

11. BIRTHPLACE (State or foreign country)

NEW YORK

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO. A

117-01-9709

17. INFORMANT

ST AGNES HOSPITAL RECORDS CATON &  
WILKENS AVES BALTO MD 21229

ADDRESS

18. 412131

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

Cerebrovascular Hemorrhage

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Heart Disease

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from 09/07 1972 to 09/11 1972,  
that ☒ (we) last saw the deceased alive on 09/11 1972 and that in ☒ (our) opinion death occurred on the date  
and hour and from the causes stated above. ☒ (We) (did) ☒ view the body after death.

23A. SIGNATURE

Donato A. Vargas Jr.

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

9-11-72

23C. PHYSICIAN'S  
NAME (Type)

DONATO VARGAS, M.D.

23D. ADDRESS

ST AGNES HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

9-14-1972

24B. NAME OF CEMETERY or CREMATORY

Gardens of Faith

24D. LOCATION

(City, town, or county)

(State)

~~Belair Rd.~~

Belair Rd. Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 14 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Hubbard Funeral Home Inc. 4107 Wilkens Ave/

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SEPTEMBER 11, 1952 6:45 P.

ST. AGNES HOSPITAL

BALTIMORE

ST. AGNES HOSPITAL

1202 NOLLYN FERRY ROAD - BALTIMORE

01 24 82

MALE CAUCASIAN

NEW YORK

ST. ANTHONY'S

ST. ANTHONY'S

UNKNOWN

UNKNOWN

ST. AGNES HOSPITAL RECORDS SECTION  
WILKINS AVENUE BALTIMORE 38

11-11-52

NO

NO

02/11

73

02/10

XX

73

02/11

XX

XX

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

1

B-100 72 08815 STATE OF MARYLAND, DEPT. OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT 72 08815

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANDREW BOVA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 9 9 1972                                                                                                 |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>BON SECOURS HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                      |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 9, 1972 8:40 A.M.</b>                                                                                                                             |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7. RACE<br><b>White</b>                                                                                                                                                                                          |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                              |  |
| 9. DATE OF BIRTH<br><b>10-30-1901</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | D. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                             |  |
| 10. AGE (In years last birthday)<br><b>70</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | E. STREET AND NUMBER<br><b>331 Arion Park Drive</b>                                                                                                                                                              |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                    |  |
| 13. FATHER'S NAME<br><b>Peter Bova</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2551</b>                                                                         |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br><b>Sebastina Messineo</b>                                                                                                                                                            |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.<br><b>216-07-5454</b>                                                                                                                                                                    |  |
| 18. INFORMANT<br><b>Mrs. Evelyn Bova</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | ADDRESS<br><b>331 Oaklee Village, 21229</b>                                                                                                                                                                      |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>BRONCHOPNEUMONIA AND HEPATIC FAILURE</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) IMMEDIATE CAUSE<br/>DUE TO, OR AS A CONSEQUENCE OF:<br/>(B) Gunshot wound of abdomen<br/>DUE TO, OR AS A CONSEQUENCE OF:<br/>(C) _____</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                     |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                  |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                 |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Bar</b>                                                                                                           |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>2238 Frederick Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>8-24-72 10:30 P.M.</b>                                                                                                                           |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22F. HOW DID INJURY OCCUR?<br><b>Gunshot wound of abdomen</b>                                                                                                                                                    |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                                              |  |                                                                                                                                                                                                                  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>9/10/72</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE<br><b>9-13-1972</b>                                                                                                                                                                                    |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Oaklawn Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br><b>Eastern Ave. Balto Co. Md.</b>                                                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR<br><b>Sidney J. Kornblum</b>                                                                                                                                                              |  |
| 25C. FUNERAL DIRECTOR<br><b>Hubbard Funeral Home, 4107 Wilkens Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><b>4107 Wilkens Ave.</b>                                                                                                                                                                              |  |

VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                          | REG. NO. 72 08816                                                           |                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| BIRTH NO. 5-760                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 72 08816                                                                                                                                                    |                                                                                                                                                                                                                                                          | CERTIFICATE OF DEATH                                                        |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Julia Sebra</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><i>9-10-72</i> <i>9 A.</i> M.                                                                                                                                                                                               |                                                                             |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>90 Caton Manor Nursing Center</i>                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>md.</i> B. COUNTY <i>AA</i>                                                                                                                         |                                                                             |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | C. CITY OR TOWN <i>Baltimore</i>                                                                                                                                                                                                                         |                                                                             | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | E. STREET AND NUMBER<br><i>66 S. Old Annapolis Rd.</i>                                                                                                                                                                                                   |                                                                             |                                                                                               |
| 5. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                                                                                                          | 8. DATE OF BIRTH<br><i>1-29-06</i>                                          | 9. AGE (In years lost birthday)<br><i>66</i>                                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Nurse</i>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>                                                                                                         |                                                                                                                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country)<br><i>KANSAS</i>                  |                                                                                               |
| 13. FATHER'S NAME<br><i>Unknown</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><i>unknown</i>                                                                                                                                                                                                               |                                                                             |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 16. SOCIAL SECURITY NO.<br><i>253-30-4933</i>                                                                                                               |                                                                                                                                                                                                                                                          | 17. INFORMANT<br><i>Reverend M. Zumbrun, 300 W. Maple Rd. Lt. Md.</i>       |                                                                                               |
| 18. <i>4-12-41</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><i>II</i><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><br>19A. DATE OF OPERATION<br><i>6</i> |                         |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____<br><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                             |                                                                                               |
| MEDICAL CERTIFICATION<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                |                                                                             |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                          | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |                                                                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                          | 21F. HOW DID INJURY OCCUR?                                                  |                                                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7-10-72</i> 19 to <i>9-10-72</i> 19, that (I) (we) last saw the deceased alive on <i>9-8-72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                          |                                                                             |                                                                                               |
| 23A. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><i>9/10/72</i>                                                                                                                                                                                                                       |                                                                             | 23C. PHYSICIAN'S NAME (Type)<br><i>MIGUEL A. HEREDIA, M.D.</i>                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 24B. DATE<br><i>9-13-1972</i>                                                                                                                                                                                                                            |                                                                             | 24C. NAME OF CEMETERY or CREMATORY<br><i>Loudon Park Cemetery</i>                             |
| 24D. LOCATION (City, town, or county) (State)<br><i>Wilkens Ave. Baltimore, Md.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 14 1972</i>                                                                                                                                                                                                    |                                                                             |                                                                                               |
| 25B. NAME OF REGISTRAR<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><i>Hubbard Funeral Home Inc.</i>                                                                                                                                                                                                |                                                                             |                                                                                               |
| 25D. ADDRESS<br><i>4107 Wilkens Ave.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                          |                                                                             |                                                                                               |



Released on approval By Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

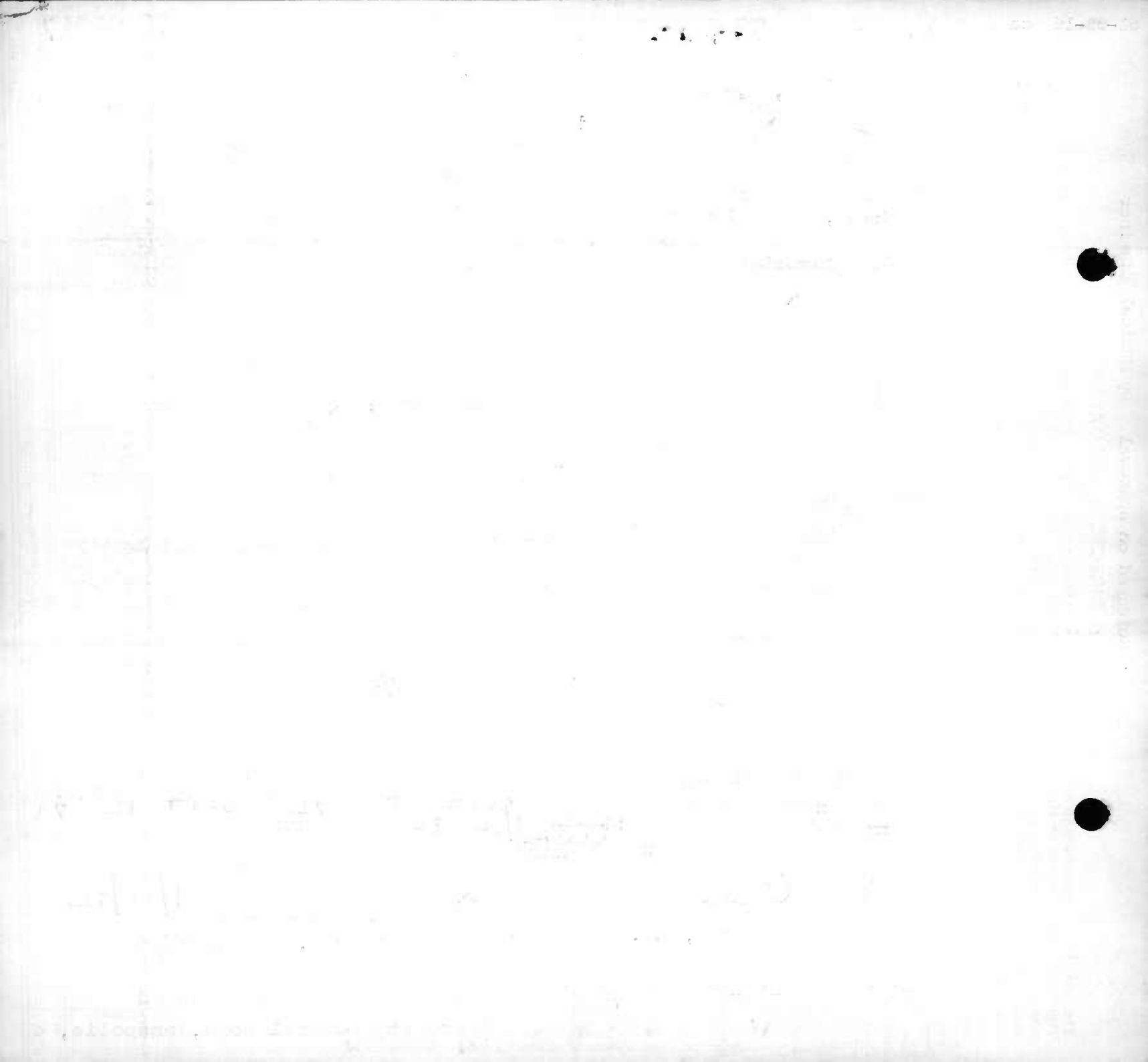
M-62072-08817BALTIMORE CITY HEALTH DEPARTMENT72 08817

CERTIFICATE OF DEATH

REG. NO. STATE OF MARYLAND-DEMT

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             |                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                             |
| 1. NAME OF DECEASED<br>(Type or Print)<br>MEYERS, FREDERICK Lee III                                                                                                                                                                                                                                                                                                                                                                               |                      | 9-12-72 6:25 A.M.                                                                                                                                           |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                            |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY<br>Md. ANN ARUND                                |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br>BALTIMORE CITY HOSPITALS<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                                                                                                                                                                                      |                      | C. CITY OR TOWN<br>ANNAPOLIS<br>D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                          |                             |
| E. STREET AND NUMBER<br>ROUTE 2 BOX 287                                                                                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             |                             |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br>Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>9-30-65 |
| 9. AGE (in years last birthday)<br>6                                                                                                                                                                                                                                                                                                                                                                                                              |                      | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                                   |                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                       |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                             |
| 11. BIRTHPLACE (State or foreign country)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                             |                      | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                         |                             |
| 13. FATHER'S NAME<br>DONALD MEYERS                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 14. MOTHER'S MAIDEN NAME<br>RUTH Anna Pechart                                                                                                               |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                                                                                                                                    |                      | 16. SOCIAL SECURITY NO.<br>none                                                                                                                             |                             |
| 17. INFORMANT<br>BCH RECORDS: 4940 Eastern Avenue                                                                                                                                                                                                                                                                                                                                                                                                 |                      | ADDRESS                                                                                                                                                     |                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>HYPERKALEMIA<br>DUE TO, OR AS A CONSEQUENCE OF:<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>RENAL FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>45% BURN |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 day<br>4 days<br>4 days                                                                                   |                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |                             |
| 19A. DATE OF OPERATION<br>9-12-72                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>RENAL FAILURE                                                                                           |                             |
| 20A. AUTOPSY? (Yes or No)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                             |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>home                                                            |                             |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>ANNAPOLIS 5200                                                                                                                                                                                                                                                                                                                                                        |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>9 8 72 4PM                                                                                     |                             |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                      | 21F. HOW DID INJURY OCCUR?<br>CHILD SAID TO HAVE BEEN PLAYING WITH MATCHES                                                                                  |                             |
| 22. I certify that (1) (this hospital) attended the deceased from SEPT. 8 1972 to SEPT 12 1972 that (1) last saw the deceased alive on 9/12/1972 and that (1) (our) applan death occurred on the date and hour and from the causes stated above. (1) (We) (did) view the body after death.                                                                                                                                                        |                      |                                                                                                                                                             |                             |
| 23A. SIGNATURE<br>Edward Luce, M.D.                                                                                                                                                                                                                                                                                                                                                                                                               |                      | 23B. DATE SIGNED<br>9/12/72                                                                                                                                 |                             |
| 23C. PHYSICIAN'S NAME (Type)<br>Edward Luce, M.D.                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 23D. ADDRESS<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                            |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                |                      | 24B. DATE<br>9-14-72                                                                                                                                        |                             |
| 24C. NAME OF CEMETERY OR CREMATORY<br>Hillcrest Cemetery                                                                                                                                                                                                                                                                                                                                                                                          |                      | 24D. LOCATION (City, town, or county) (State)<br>Annapolis AACo Md                                                                                          |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 14 1972                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 25B. NAME OF REGISTRAR<br>Hardesty Funeral Home, Annapolis, Md                                                                                              |                             |
| 25C. FUNERAL DIRECTOR<br>Hardesty Funeral Home, Annapolis, Md                                                                                                                                                                                                                                                                                                                                                                                     |                      | ADDRESS                                                                                                                                                     |                             |



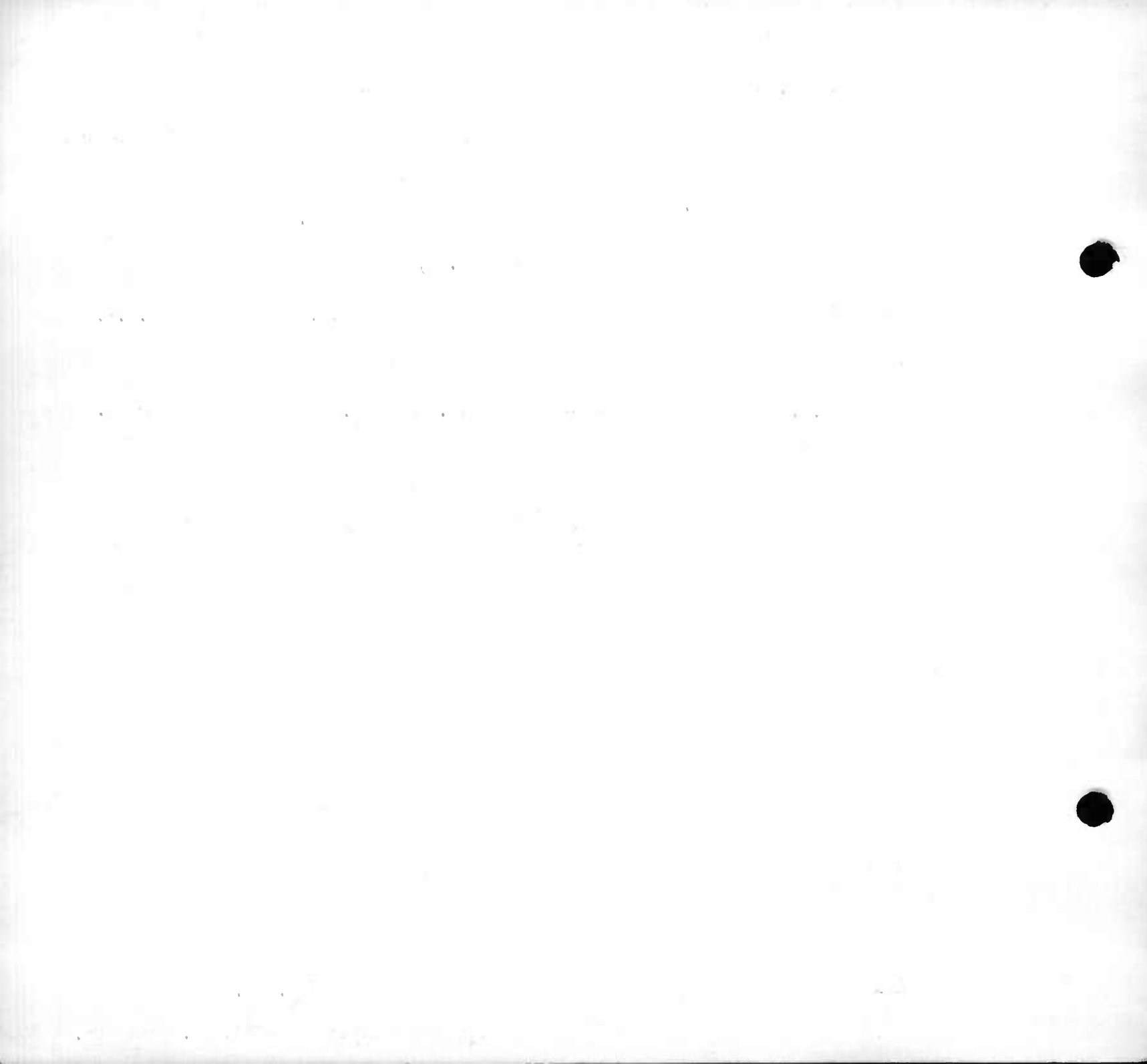




# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | REG. NO. 72 08818                                                                          |                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| D-500 72 08818                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | STATE OF MARYLAND-DEMD                                                                     |                                                                  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | 2. DATE AND HOUR OF DEATH                                                                  |                                                                  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Samuel F. Demma</i>                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | 9-8-72                                                                                     |                                                                  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)      |                                                                  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | A. STATE <i>Maryland</i>                                                                   |                                                                  |
| <i>00 1619 Patapsco St.</i>                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | B. COUNTY <i>2302</i>                                                                      |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | C. CITY OR TOWN <i>Baltimore</i>                                                           |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | E. STREET AND NUMBER <i>1619 Patapsco St.</i>                                              |                                                                  |
| 5. SEX <i>M</i>                                                                                                                                                                                                                                                                                                                                      | 6. RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Mar. 15, 1896</i>                                                                                                                                                                                                                                                   | 9. AGE (in years last birthday) <i>76</i>                                                  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inspector</i>                                                                                                                                                                                                                                         |                  |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY <i>Lumber</i>                                                                                                                                                                                                                                         |                                                                                            | 11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             | 13. FATHER'S NAME <i>Anthony Demma</i>                                                                                                                                                                                                                                                  |                                                                                            |                                                                  |
| 14. MOTHER'S MAIDEN NAME <i>Marie Conso</i>                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W.W.1</i>                                                                                                                                                               |                                                                                            |                                                                  |
| 16. SOCIAL SECURITY NO. <i>213-10-5388A</i>                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             | 17. INFORMANT ADDRESS <i>Mrs. Mabel B. Demma 1619 Patapsco St. Wife</i>                                                                                                                                                                                                                 |                                                                                            |                                                                  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                  |                  |                                                                                                                                                             | CAUSE OF DEATH<br><i>Metastatic Carcinoma</i><br><i>Left Lung, secondary</i><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Metastatic Carcinoma</i><br><i>Intense atherosclerotic Cardio-Vascular</i><br>DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes</i><br>(C) _____ |                                                                                            |                                                                  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 months</i>                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>years</i>                                                                                                                                                                                                                            |                                                                                            |                                                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         |                                                                                            |                                                                  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                               |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                         | 20A. AUTOPSY? (Yes or No)                                                                  |                                                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |                                                                  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                            |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                         | 21F. HOW DID INJURY OCCUR?                                                                 |                                                                  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-20</i> 19 <i>68</i> to <i>9-8</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>9-8-</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         |                                                                                            |                                                                  |
| 23A. SIGNATURE <i>Roberto V. Gonzalez</i>                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | 23B. DATE SIGNED <i>9-5-72</i>                                                             |                                                                  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | 23D. ADDRESS                                                                               |                                                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                             |                  | 24B. DATE                                                                                                                                                   |                                                                                                                                                                                                                                                                                         | 24C. NAME of CEMETERY or CREMATORY                                                         |                                                                  |
| <i>Burial</i>                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | <i>Holy Cross Cemetery</i>                                                                 |                                                                  |
| 24D. LOCATION (City, town, or county)                                                                                                                                                                                                                                                                                                                |                  | 24E. NAME of REGISTRAR                                                                                                                                      |                                                                                                                                                                                                                                                                                         | 24F. FUNERAL DIRECTOR                                                                      |                                                                  |
| <i>Balto. Md.</i>                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                         | <i>McCollum Funeral Home</i>                                                               |                                                                  |
| 24G. ADDRESS                                                                                                                                                                                                                                                                                                                                         |                  | 24H. ADDRESS                                                                                                                                                |                                                                                                                                                                                                                                                                                         | 24I. ADDRESS                                                                               |                                                                  |
| <i>130 E. Font Ave.</i>                                                                                                                                                                                                                                                                                                                              |                  | <i>21230</i>                                                                                                                                                |                                                                                                                                                                                                                                                                                         | <i>21230</i>                                                                               |                                                                  |



| STATE OF MARYLAND-DEMH                                                                                                                                                                                                                                                                                                                                                                                        |                                               | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                          |                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| D-250                                                                                                                                                                                                                                                                                                                                                                                                         |                                               | 72 08819                                                                                                                                                                  |                                                                 |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |                                               | REG. NO. 72 08819                                                                                                                                                         |                                                                 |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |                                               |                                                                                                                                                                           |                                                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GEORGE W. DIXON</b>                                                                                                                                                                                                                                                                                                                                                 |                                               | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/> <b>9 8 72</b> M.                                                                    |                                                                 |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1617 Desoto Road</b>                                                                                                                                                                                                                    |                                               | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 8, 1972 6:30 P.</b> M.                                                                                     |                                                                 |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2582</b>                                                                                                                                                                                                                                                                       |                                               | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                               |                                                                 |
| 6. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                            | 7. RACE <b>White</b>                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                  |                                                                 |
| 9. DATE OF BIRTH <b>Mar. 18, 1909</b>                                                                                                                                                                                                                                                                                                                                                                         | 10. AGE (In years last birthday) <b>63</b>    | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                 |                                                                 |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                    |                                               | 13. FATHER'S NAME <b>William Dixon</b>                                                                                                                                    |                                                                 |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>                                                                                                                                                                                                                                                                                                     |                                               | 15. MOTHER'S MAIDEN NAME <b>Isabelle Rawlings</b>                                                                                                                         |                                                                 |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>                                                                                                                                                                                                                                                                                             |                                               | 17. SOCIAL SECURITY NO. <b>Walton R. Dixon 3604 Century Ave. 21227</b>                                                                                                    |                                                                 |
| 19. <b>1621 I</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                               | CAUSE OF DEATH                                                                                                                                                            |                                                                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                |                                               | Carcinoma of lung                                                                                                                                                         |                                                                 |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |                                               | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                    |                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                               |                                               | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                       |                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                               |                                               | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                       |                                                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                        |                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                              |                                                                 |
| 20A. DATE OF OPERATION <b>9-14-72</b>                                                                                                                                                                                                                                                                                                                                                                         |                                               | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                          |                                                                 |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |                                               | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                  |                                                                 |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |                                               | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                 |                                                                 |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |                                               | 22F. HOW DID INJURY OCCUR?                                                                                                                                                |                                                                 |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                               |                                                                                                                                                                           |                                                                 |
| ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>                                                                                                                                                                                                                                                                                                                                                              |                                               | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |                                                                 |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |                                               | DATE SIGNED <b>9/9/72</b>                                                                                                                                                 |                                                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                        | 24B. DATE <b>9-14-72</b>                      | 24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemt.</b>                                                                                                                | 24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b> |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                            | 25B. NAME OF REGISTRAR <b>Audrey H. H. H.</b> | 25C. FUNERAL DIRECTOR <b>McCully Funeral Home</b>                                                                                                                         | ADDRESS <b>130 E. Font Ave. 21230</b>                           |

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>JAMES BURKE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.      |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Church Home &amp; Hosp. (DOA)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>9 10 1972 3:50 p.m.</b>                                         |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE<br><b>white</b>                                                                                              |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | C. CITY OR TOWN<br><b>Balto.</b>                                                                                     |  |
| 9. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 10. AGE (In years lost birthday) <b>8</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | E. STREET AND NUMBER<br><b>731 S. Bond St.</b>                                                                       |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. CITIZEN OF<br><b>U. S. A.</b>                                                                                    |  |
| 13. FATHER'S NAME<br><b>Guy L. Burke</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>       |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Wanda J. Waybright</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |  |
| 17. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 18. INFORMANT (Father) <b>731 South Bond St. Mr. Guy L. Burke, Balto. Md. 21231</b>                                  |  |
| 19. <b>E910.10</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Drowning</b><br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                         |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                     |  |
| 21. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                      |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>pier</b>              |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>1600 blk. Thames St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>9-10-72 9:40 a.m.</b>                                          |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22F. HOW DID INJURY OCCUR?<br><b>Fell off pier into water.</b>                                                       |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>W P Mulloy</b> M.D.<br>EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>9-11-72</b> |  |                                                                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 24B. DATE<br><b>9/13/72</b>                                                                                          |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Gardens of Faith Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR<br><b>Aditya...</b>                                                                           |  |
| 25C. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25D. ADDRESS                                                                                                         |  |

Drumming

plan

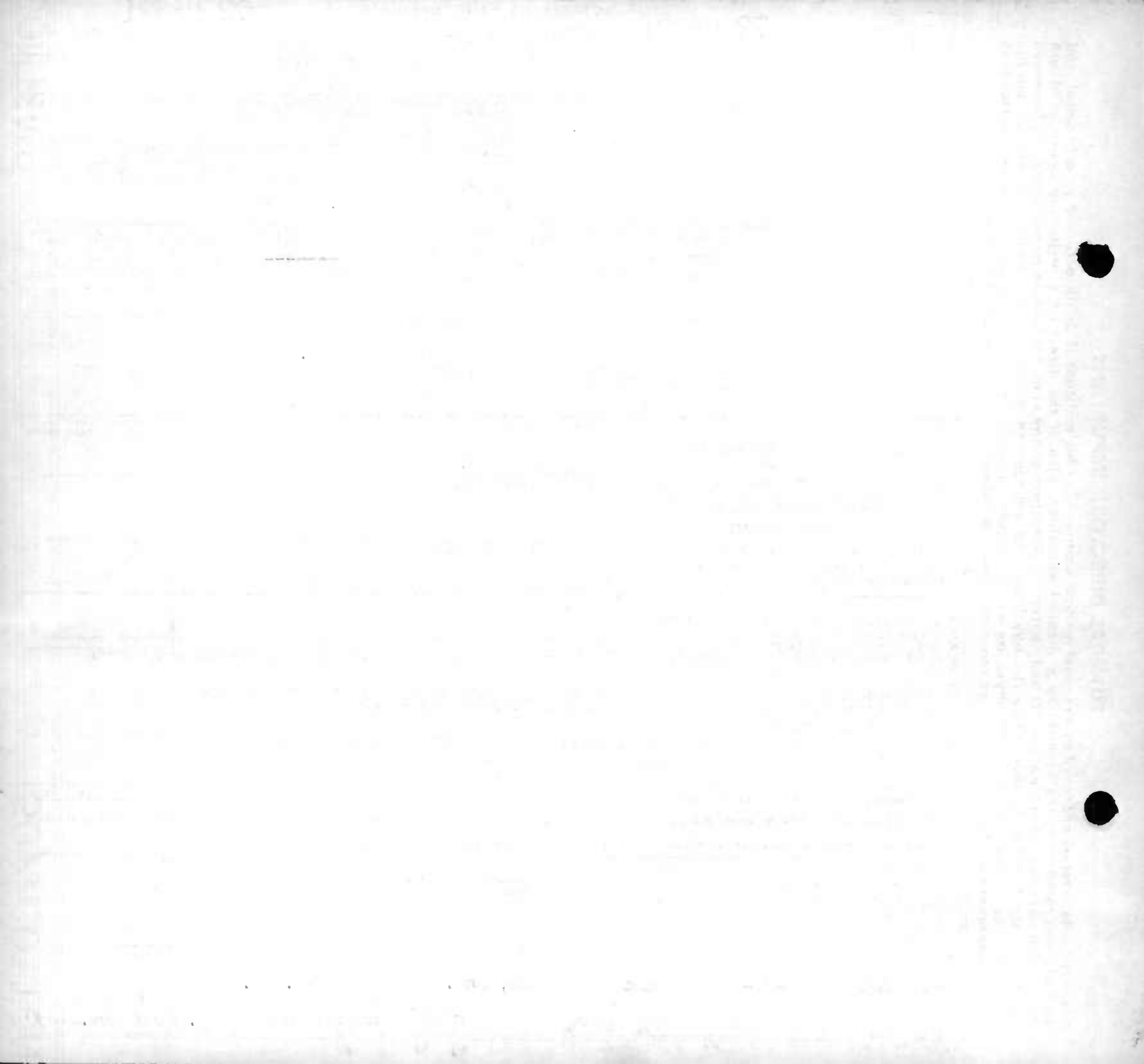
at 10:00 off road into west.

*W. J. Murray*  
William J. Murray, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| T-65202                                                                                                                                                                                                                                                                                                                                              |  | T-152                                            |                                                                      | 72 08821                                                                                                  |  | BALTIMORE CITY HEALTH DEPT.                                                                                                             |  | 72 08821                                                                            |                                                                                               | REG. NO.                                                           |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                            |  | 72-12277                                         |                                                                      | 72 08821                                                                                                  |  | BALTIMORE CITY HEALTH DEPT.                                                                                                             |  | 72 08821                                                                            |                                                                                               | REG. NO.                                                           |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Baby Girl Tornkvist</i>                                                                                                                                                                                                                                                                                    |  |                                                  |                                                                      |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><i>8/27/72</i> <i>12 45 AM</i> M.                                                                          |  |                                                                                     |                                                                                               |                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                               |  |                                                  |                                                                      |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>2402</i> |  |                                                                                     |                                                                                               |                                                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>South Baltimore General Hosp.</i><br><i>43</i>                                                                                                                                                                                                                                                            |  |                                                  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |                                                                                                           |  | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                     |  |                                                                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                    |  |
| 5. SEX <i>F</i> 6. RACE <i>Caucasian</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                    |  |                                                  |                                                                      |                                                                                                           |  | 8. DATE OF BIRTH<br><i>8/26/72</i>                                                                                                      |  | 9. AGE (In years last birthday)<br><i>1 day</i>                                     |                                                                                               | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                          |  |                                                  |                                                                      |                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                                                                            |  |                                                                                     | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>                                                   |                                                                    |  |
| 13. FATHER'S NAME<br><i>David Tornkvist</i>                                                                                                                                                                                                                                                                                                          |  |                                                  |                                                                      |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><i>Violet Brown</i>                                                                                         |  |                                                                                     |                                                                                               |                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service                                                                                                                                                                                                                                               |  |                                                  |                                                                      |                                                                                                           |  | 16. SOCIAL SECURITY NO.                                                                                                                 |  | 17. INFORMANT ADDRESS<br><i>Hospital record</i>                                     |                                                                                               |                                                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.               |  |                                                  |                                                                      |                                                                                                           |  | CAUSE OF DEATH                                                                                                                          |  |                                                                                     |                                                                                               |                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                      |  |                                                  |                                                                      |                                                                                                           |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Hyaline Membrane Disease</i>                                                  |  |                                                                                     |                                                                                               |                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                      |  |                                                  |                                                                      |                                                                                                           |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Prematurity</i>                                                                               |  |                                                                                     |                                                                                               |                                                                    |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                 |  |                                                  |                                                                      |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                            |  |                                                                                     |                                                                                               |                                                                    |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                               |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED |                                                                      | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                                                    |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                    |  |                                                                                     |                                                                                               |                                                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                |  |                                                  |                                                                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                |  |                                                                                     |                                                                                               |                                                                    |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                            |  |                                                  |                                                                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                              |  |                                                                                     |                                                                                               |                                                                    |  |
| 22. I certify that (if this hospital) attended the deceased from <i>8/26</i> 19 <i>72</i> to <i>8/27</i> 19 <i>72</i> that (if we) last saw the deceased alive on <i>8/27</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death. |  |                                                  |                                                                      |                                                                                                           |  |                                                                                                                                         |  |                                                                                     |                                                                                               |                                                                    |  |
| 23A. SIGNATURE<br><i>James A. Kopper M.D.</i>                                                                                                                                                                                                                                                                                                        |  |                                                  |                                                                      |                                                                                                           |  | 23B. DATE SIGNED<br><i>8/27/72</i>                                                                                                      |  | 23C. PHYSICIAN'S NAME (Type)<br><i>James A. Kopper M.D.</i>                         |                                                                                               |                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Cremation</i>                                                                                                                                                                                                                                                                                         |  |                                                  |                                                                      |                                                                                                           |  | 24B. DATE<br><i>9-14-72</i>                                                                                                             |  | 24C. NAME of CEMETERY or CREMATORY<br><i>Security Process, Inc.</i>                 |                                                                                               | 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 14 1972</i>                                                                                                                                                                                                                                                                                                |  |                                                  |                                                                      |                                                                                                           |  | 25B. NAME OF REGISTRAR<br><i>Shirley Whitton</i>                                                                                        |  | 25C. FUNERAL DIRECTOR ADDRESS<br><i>McCully Funeral Home 130 E. Font Ave. 21230</i> |                                                                                               |                                                                    |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                           |                                                         |                                                                                                                                 |                                                                             |                                                                                               |                                   |  |
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| G-565 72 08822                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                           |                                                         | X REG. NO. 72 08822                                                                                                             |                                                                             |                                                                                               |                                   |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                           |                                                         | STATE OF MARYLAND - DEPT.                                                                                                       |                                                                             |                                                                                               |                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GAMERMAN PEARL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                           |                                                         | 2. DATE AND HOUR OF DEATH<br><b>9-7-72 10:05 AM</b>                                                                             |                                                                             |                                                                                               |                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                           |                                                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                           |                                                                             |                                                                                               |                                   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>42 SINAI HOSPITAL OF BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                           |                                                         | A. STATE<br><b>MARYLAND</b>                                                                                                     |                                                                             | B. COUNTY<br><b>BALTO</b>                                                                     |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                                                                                           |                                                         | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                             |                                                                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                                                                                           |                                                         | E. STREET AND NUMBER<br><b>6825 PIMLICO DRIVE</b>                                                                               |                                                                             |                                                                                               |                                   |  |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-28-19</b>                                                                        |                                                         | 9. AGE (In years last birthday)<br><b>53</b>                                                                                    | If Under 1 Yr. Months Days                                                  |                                                                                               | If Under 24 Hrs. Hours Min.       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SUPERVISOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>HECHT CO. APPLIANCE DEPT.</b>                                     |                                                         | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>                                                         |                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                    |                                   |  |
| 13. FATHER'S NAME<br><b>ISADORE HAVELOCK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>FANNIE ?</b>                                                               |                                                         |                                                                                                                                 |                                                                             |                                                                                               |                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>214-12-9828</b>                                                             |                                                         | 17. INFORMANT ADDRESS<br><b>MR. HILLARD GAMERMAN, 5825 PIMLICO DR. #21209</b>                                                   |                                                                             |                                                                                               |                                   |  |
| 18. CAUSE OF DEATH<br><b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>1338</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         |                                                                                                                                                             |                                                                                                           |                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>C.A. COLON, CAECUMITIS TO SIG</b>                                            |                                                                             |                                                                                               |                                   |  |
| 19A. DATE OF OPERATION<br><b>9-28-72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>POOR</b>                                           |                                                         | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                          |                                                                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                                         | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                     |                                                                             |                                                                                               |                                   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                         | 21F. HOW DID INJURY OCCUR?                                                                                                      |                                                                             |                                                                                               |                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7-10</b> 19 <b>72</b> to <b>9-4</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9-7</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                                                           |                                                         |                                                                                                                                 |                                                                             |                                                                                               |                                   |  |
| 23A. SIGNATURE<br><b>Sahachai Musikabhuntra</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                                                                                           |                                                         | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                                                             |                                                                                               | 23B. DATE SIGNED<br><b>9/7/72</b> |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>SAHASCHAI MUSIKABHUNTRA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                           |                                                         | 23D. ADDRESS<br><b>SINAI HOSPITAL</b>                                                                                           |                                                                             |                                                                                               |                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 24B. DATE<br><b>9/11/72</b>                                                                                                                                 |                                                                                                           | 24C. NAME OF CEMETERY or CREMATORY<br><b>BETH JACOB</b> |                                                                                                                                 | 24D. LOCATION (City, town, or county) (State)<br><b>FINKSBURG, MARYLAND</b> |                                                                                               |                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br><b>A. Levinson</b>                                                              |                                                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>                                        |                                                                             |                                                                                               |                                   |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  |                                                                                       |                       |                                                                      |                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------|-----------------------------|
| S-450                                                                                                                                                                                                                                                                                                            |         | 72 08823                                                                                                                         |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                       | REG. NO. 72 08823                                                    |                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                                        |         | 1. NAME OF DECEASED<br>(Type or Print)                                                                                           |                  | 2. DATE AND HOUR OF DEATH                                                             |                       | STATE OF MARYLAND - DISTRICT                                         |                             |
|                                                                                                                                                                                                                                                                                                                  |         | SONIA (SULTANA) SHALOM                                                                                                           |                  | SEPT. 10/72                                                                           |                       | 8:00 A.M.                                                            |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                           |         |                                                                                                                                  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                       |                                                                      |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                     |         |                                                                                                                                  |                  | A. STATE B. COUNTY                                                                    |                       |                                                                      |                             |
| 00 3612 Bowers Avenue Apt. D                                                                                                                                                                                                                                                                                     |         |                                                                                                                                  |                  | Maryland                                                                              |                       |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  | C. CITY OR TOWN                                                                       |                       | D. INSIDE CITY LIMITS?                                               |                             |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  | Baltimore                                                                             |                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                             |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  | E. STREET AND NUMBER                                                                  |                       |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  | 3612 Bowers Avenue Apt. D.                                                            |                       |                                                                      |                             |
| 5. SEX                                                                                                                                                                                                                                                                                                           | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>                                            | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                                       | If Under 1 Yr. Months | If Under 24 Hrs. Days                                                | If Under 24 Hrs. Hours Min. |
| Female                                                                                                                                                                                                                                                                                                           | White   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                               | Dec. 26, 1923    | 48                                                                                    |                       |                                                                      |                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                      |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                |                  | 11. BIRTHPLACE (State or foreign country)                                             |                       | 12. CITIZEN OF WHAT COUNTRY?                                         |                             |
| Secretary                                                                                                                                                                                                                                                                                                        |         | First National Bank                                                                                                              |                  | Turkey                                                                                |                       | USA+                                                                 |                             |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                |         |                                                                                                                                  |                  | 14. MOTHER'S MAIDEN NAME                                                              |                       |                                                                      |                             |
| Moise Shalom                                                                                                                                                                                                                                                                                                     |         |                                                                                                                                  |                  | Anna ?                                                                                |                       |                                                                      |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                         |         | 16. SOCIAL SECURITY NO.                                                                                                          |                  | 17. INFORMANT ADDRESS                                                                 |                       |                                                                      |                             |
| No                                                                                                                                                                                                                                                                                                               |         |                                                                                                                                  |                  | 21208 Mrs. Raphael Nigrin 8204 Scotts Level Rd.                                       |                       |                                                                      |                             |
| 18. I                                                                                                                                                                                                                                                                                                            |         | CAUSE OF DEATH                                                                                                                   |                  |                                                                                       |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                   |         | Ref. to lab. Ovarian Carcinoma                                                                                                   |                  |                                                                                       |                       | 1+ yr.                                                               |                             |
| (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                     |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                              |                  |                                                                                       |                       |                                                                      |                             |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                |         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |                  |                                                                                       |                       |                                                                      |                             |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                        |         | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |                  |                                                                                       |                       |                                                                      |                             |
| II                                                                                                                                                                                                                                                                                                               |         | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                  |                                                                                       |                       |                                                                      |                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |                  | 20A. AUTOPSY? (Yes or No)                                                             |                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  |                                                                                       |                       |                                                                      |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                            |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                         |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                       |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  |                                                                                       |                       |                                                                      |                             |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                    |         | 21E. INJURY OCCURRED                                                                                                             |                  | 21F. HOW DID INJURY OCCUR?                                                            |                       |                                                                      |                             |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                      |         | While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>                                                |                  |                                                                                       |                       |                                                                      |                             |
|                                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  |                                                                                       |                       |                                                                      |                             |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 7 1971 to Sept 10 1972, that (I) (we) last saw the deceased alive on Sept 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                                                                  |                  |                                                                                       |                       |                                                                      |                             |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                   |         |                                                                                                                                  |                  | 23B. DATE SIGNED                                                                      |                       |                                                                      |                             |
| Daniel Bakal MD                                                                                                                                                                                                                                                                                                  |         |                                                                                                                                  |                  | 9-10-72                                                                               |                       |                                                                      |                             |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                     |         |                                                                                                                                  |                  | 23D. ADDRESS                                                                          |                       |                                                                      |                             |
| Daniel Bakal                                                                                                                                                                                                                                                                                                     |         |                                                                                                                                  |                  | 3600 Lochearn Drive                                                                   |                       |                                                                      |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                         |         | 24B. DATE                                                                                                                        |                  | 24C. NAME of CEMETERY or CREMATORY                                                    |                       | 24D. LOCATION (City, town, or county) (State)                        |                             |
| Burial                                                                                                                                                                                                                                                                                                           |         | Sept. 11/72                                                                                                                      |                  | Beth El Memorial Park                                                                 |                       | Randallstown, Maryland                                               |                             |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                  |         | 25B. NAME OF REGISTRAR                                                                                                           |                  | 25C. FUNERAL DIRECTOR                                                                 |                       | ADDRESS                                                              |                             |
| SEP 14 1972                                                                                                                                                                                                                                                                                                      |         | Sidney H. [Signature]                                                                                                            |                  | Sol Levinson & Bros.                                                                  |                       | 6010 Reisterstown Rd.                                                |                             |

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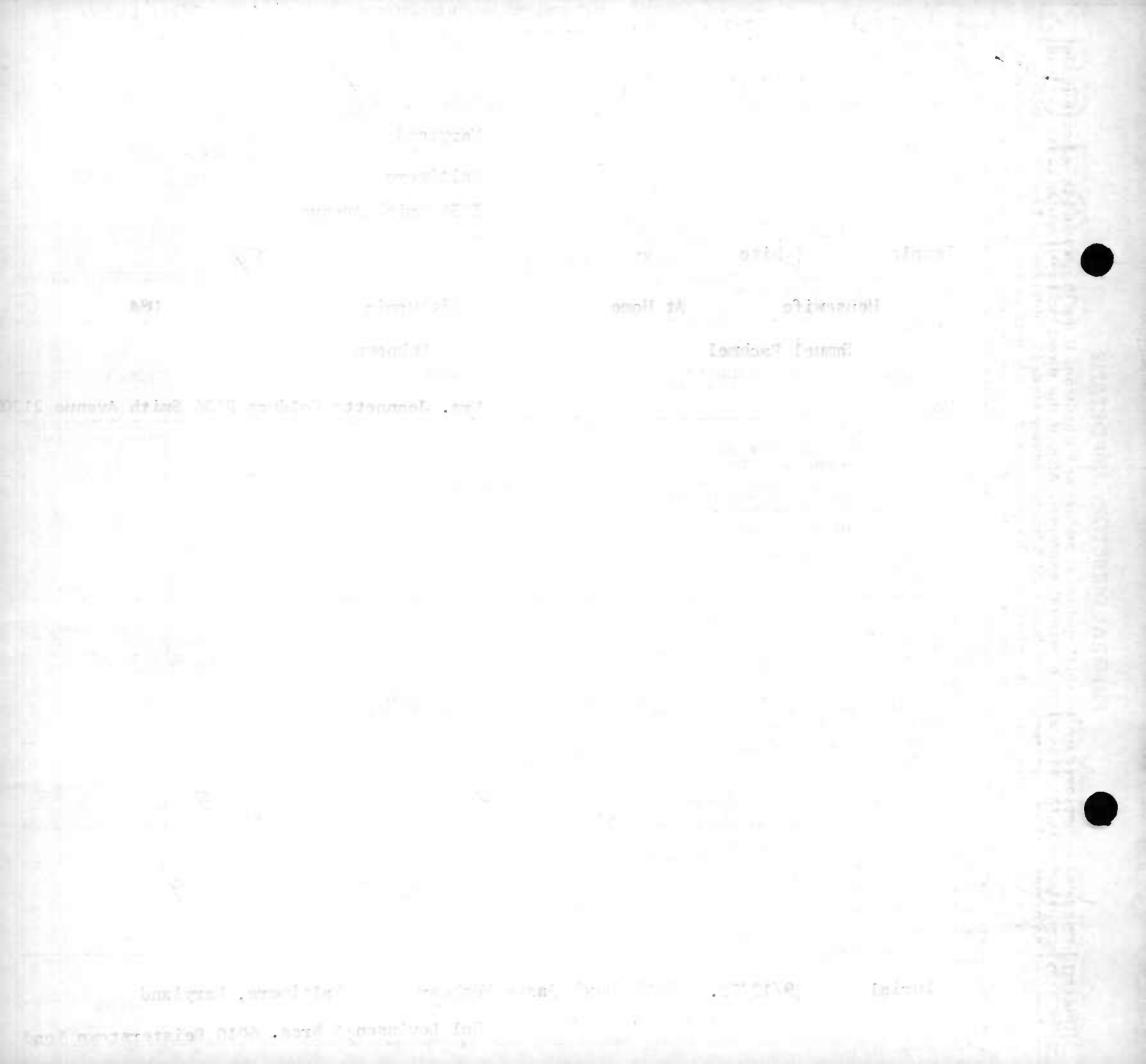
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                          |                  | 72 08824                                                                              |                            | REG. NO. 72 08824                                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. C-500                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                          |                  | 72 08824                                                                              |                            |                                                                                                                                 |  |
| 1. NAME OF DECEASED (Type or Print) <i>Cohen, Nettie</i>                                                                                                                                                                                                                                                                                              |                      |                                                                                                                                                          |                  | 2. DATE AND HOUR OF DEATH <i>9/11/72 6:00 P.M.</i>                                    |                            |                                                                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                          |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                            |                                                                                                                                 |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                                                  |                      | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                     |                  | A. STATE <i>Maryland</i>                                                              |                            | B. COUNTY <i>BALTO</i>                                                                                                          |  |
| <i>4 Sinai Hosp. of Baltimore, Inc.</i>                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                          |                  | C. CITY OR TOWN <i>Baltimore</i>                                                      |                            | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |  |
| E. STREET AND NUMBER <i>3236 Smith Avenue</i>                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                          |                  |                                                                                       |                            |                                                                                                                                 |  |
| 5. SEX <i>Female</i>                                                                                                                                                                                                                                                                                                                                  | 6. RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (in years last birthday) <i>84</i>                                             | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.                                                                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>                                                                                                                                                                                                                                          |                      | 10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>                                                                                                         |                  | 11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>                            |                            | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>                                                                                         |  |
| 13. FATHER'S NAME <i>Samuel Rachmel</i>                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                          |                  | 14. MOTHER'S MAIDEN NAME <i>Unknown</i>                                               |                            |                                                                                                                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>                                                                                                                                                                                                                                      |                      | 16. SOCIAL SECURITY NO.                                                                                                                                  |                  | 17. INFORMANT ADDRESS <i>Mrs. Jeannette Goldman 3236 Smith Avenue 21208</i>           |                            |                                                                                                                                 |  |
| 18. <i>410.91</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                          |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                            |                                                                                                                                 |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                          |                  | <i>Cardiogenic Shock</i> <i>48 hrs.</i>                                               |                            |                                                                                                                                 |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                            |                      |                                                                                                                                                          |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |                            |                                                                                                                                 |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                          |                  | <i>Acute Myocardial Infarction</i> <i>48 hrs.</i>                                     |                            |                                                                                                                                 |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                             |                      |                                                                                                                                                          |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |                            |                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                          |                  | <i>Arteriosclerotic Cardiovascular dis.</i> <i>pr. yrs.</i>                           |                            |                                                                                                                                 |  |
| II                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                          |                  |                                                                                       |                            |                                                                                                                                 |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                      |                      |                                                                                                                                                          |                  | <i>Dehydration</i> <i>pr. days.</i>                                                   |                            |                                                                                                                                 |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                  | 20A. AUTOPSY? (Yes or No)                                                             |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                            |  |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                      |                                                                                                                                                          |                  | <input type="checkbox"/>                                                              |                            |                                                                                                                                 |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                 |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                            |                                                                                                                                 |  |
| <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                      |                                                                                                                                                          |                  |                                                                                       |                            |                                                                                                                                 |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                             |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                  | 21F. HOW DID INJURY OCCUR?                                                            |                            |                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                          |                  |                                                                                       |                            |                                                                                                                                 |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/11</i> 19 <i>72</i> to <i>9/11</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>9/11</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |                                                                                                                                                          |                  |                                                                                       |                            |                                                                                                                                 |  |
| 23A. SIGNATURE <i>Veneranda C. Gerasimio, M.D.</i> DEGREE                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                          |                  | 23B. DATE SIGNED <i>9/11/72</i>                                                       |                            | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |
| 23C. PHYSICIAN'S NAME (Type) <i>Veneranda C. Gerasimio, M.D.</i> DEGREE                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                          |                  | 23D. ADDRESS <i>Sinai Hosp. of Baltimore, Inc.</i>                                    |                            |                                                                                                                                 |  |
| 24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>                                                                                                                                                                                                                                                                                                 |                      | 24B. DATE <i>9/12/72</i>                                                                                                                                 |                  | 24C. NAME OF CEMETERY OR CREMATORY <i>Beth Jacob Anshe Veshear</i>                    |                            | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 14 1972</i>                                                                                                                                                                                                                                                                                                    |                      | 25B. NAME OF REGISTRAR <i>Andrey...</i>                                                                                                                  |                  | 25C. FUNERAL DIRECTOR <i>Sal Levinson &amp; Bros.</i>                                 |                            | ADDRESS <i>6010 Reisterstown Road</i>                                                                                           |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                          | 72 08825                                                                                                                                                                                                                                                                                                                    |                                          | 72 08825                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                          | REG. NO.                                                                                                                                                                                                                                                                                                                    |                                          | STATE OF MARYLAND-DEM                                                       |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MORRIS RITZES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                          | 2. DATE AND HOUR OF DEATH<br><b>September 11, 1972 10:06 A. M.</b>                                                                                                                                                                                                                                                          |                                          |                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>42 Sinai Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                          | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2755</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>5718 Ranny Road</b> |                                          |                                                                             |  |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 13, 1911</b> | 9. AGE (In years lost birthday)<br><b>61</b>                                                                                                                                                                                                                                                                                | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min.                                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self Employed</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Paper Route</b>                                                                                                     |                                          | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                     |                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |  |
| 13. FATHER'S NAME<br><b>David Ritzes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                          | 14. MOTHER'S MAIDEN NAME<br><b>Sarah ?</b>                                                                                                                                                                                                                                                                                  |                                          |                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 16. SOCIAL SECURITY NO.<br><b>215-10-8189</b>                                                                                                               |                                          | 17. INFORMANT ADDRESS<br><b>Mrs. Mollie Ritzes 5718 Ranny Road 21209</b>                                                                                                                                                                                                                                                    |                                          |                                                                             |  |
| 18. <b>412.41</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Complete Myocardial Collapse, Chronic Arteriosclerosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>(A) Immediate Cause: Complete Myocardial Collapse, Chronic Arteriosclerosis</b><br><b>(B) Acute Atherosclerosis repaired by Proliferation, Aug 1969</b><br><b>(C) Chronic Bronchitis 1953</b> |                         |                                                                                                                                                             |                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b>                                                                                                                                                                                                                                                              |                                          |                                                                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                          |                                                                                                                                                                                                                                                                                                                             |                                          |                                                                             |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                          | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                                                                                                                                                                                                                                                                      |                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                    |                                          |                                                                             |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                          | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                  |                                          |                                                                             |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Jan 2 1953</b> to <b>Sept 11 1972</b> , that (I) (we) lost saw the deceased alive on <b>July 13 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                          |                                                                                                                                                                                                                                                                                                                             |                                          |                                                                             |  |
| 23A. SIGNATURE<br><b>Lester Kolman MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                          | 23B. DATE SIGNED<br><b>Sept. 11, 1972</b>                                                                                                                                                                                                                                                                                   |                                          |                                                                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Lester Kolman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                          | 23D. ADDRESS<br><b>6821 Reisterstown Road</b>                                                                                                                                                                                                                                                                               |                                          |                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 24B. DATE<br><b>Sept. 12/72</b>                                                                                                                             |                                          | 24C. NAME of CEMETERY or CREMATORY<br><b>Friedel-Maryland Lodge-Rosedale</b>                                                                                                                                                                                                                                                |                                          | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 25B. NAME OF REGISTRAR<br><b>Lester Kolman</b>                                                                                                              |                                          | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Sp1 Devinson &amp; Bros. 6010 Reisterstown Road</b>                                                                                                                                                                                                                                     |                                          |                                                                             |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                             |                                     | REG. NO. 72 08826                                                                                                           |                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| C-500 72 08826                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |                                     | STATE OF MARYLAND-DHMH                                                                                                      |                                                        |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |                                     | 2. DATE AND HOUR OF DEATH                                                                                                   |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print) <b>COHEN, MIRIAM. N.</b>                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |                                     | SEPTEMBER 9, 1972 05:10 A.M.                                                                                                |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |                                     | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)                                        |                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b><br>44                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                     | A. STATE <b>MARYLAND</b> , B. COUNTY <b>U.S.A.</b> <b>1301</b>                                                              |                                                        |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |                                     | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                        |
|                                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |                                     | E. STREET AND NUMBER<br><b>2601 MADISON AVENUE</b>                                                                          |                                                        |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                        | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3. 4. 10</b> | 9. AGE (In years last birthday)<br><b>62</b>                                                                                | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>                                                                                                                                                                                                                                                |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                                                                                            |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                                                     |                                                        |
| 13. FATHER'S NAME<br><b>Momey E. Cohen</b>                                                                                                                                                                                                                                                                                                                |                     | 14. MOTHER'S MAIDEN NAME<br><b>Emma Unknown</b>                                                                                                             |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                  |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                     |                     | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                     | 17. INFORMANT<br><b>Apt. 705 E. ADDRESS</b><br><b>Mr. Milton Leven 100 W. Cold Spring Lane</b>                              |                                                        |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |                                     |                                                                                                                             |                                                        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>ELECTROLYTE IMBALANCE</b> 3 DAYS                                                                                                                       |                     |                                                                                                                                                             |                                     |                                                                                                                             |                                                        |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>SEPTICEMIA</b> 5 DAYS                                                                                                                                                                                                |                     |                                                                                                                                                             |                                     |                                                                                                                             |                                                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>A S C U D</b>                                                                                                                                                                                                      |                     |                                                                                                                                                             |                                     |                                                                                                                             |                                                        |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                    |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                     | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>                                                               |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)                                                                                                                                                                                                                                                                     |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                    |                                                        |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                 |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                     | 21F. HOW DID INJURY OCCUR?                                                                                                  |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9.8.72</b> 19 <b>72</b> to <b>9.9.</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9.9.72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                             |                                     |                                                                                                                             |                                                        |
| 23A. SIGNATURE<br><i>Carlos H. Santillan</i>                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                     | 23B. DATE SIGNED<br><b>9.9.72</b>                                                                                           |                                                        |
| 23C. PHYSICIAN'S NAME (Typel)<br><b>CARLOS H. SANTILLAN</b>                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |                                     | 23D. ADDRESS<br><b>THE UNION MEMORIAL HOSPITAL</b><br><b>BALTO, MD 21218</b>                                                |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                 |                     | 24B. DATE<br><b>Sept. 12/72</b>                                                                                                                             |                                     | 24C. NAME of CEMETERY or CREMATORY<br><b>Druid Ridge</b>                                                                    |                                                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                     |                     | 25B. NAME OF REGISTRAR<br><i>David Johnson</i>                                                                                                              |                                     | 25C. FUNERAL DIRECTOR<br><b>Sol Levinson &amp; Bros. Inc. 6010 Reisterstown</b>                                             |                                                        |
| 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Maryland</b>                                                                                                                                                                                                                                                                              |                     | ADDRESS Road                                                                                                                                                |                                     |                                                                                                                             |                                                        |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                             |                         | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                      | REG. NO.                                                                                              |                                                            | 72 08827                                                                                      |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>DUBIN BECKIE</i>                                                                                                                                                                                                                                                                                            |                         | 2. DATE AND HOUR OF DEATH<br><i>9-11-72 4:00 A.M.</i>                                                                                                       |                                      | STATE OF MARYLAND - <i>DEMD</i>                                                                       |                                                            |                                                                                               |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                                      | A. STATE<br><i>NEW YORK</i>                                                                           |                                                            |                                                                                               |                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>SINAI HOSPITAL OF BALTIMORE</i>                                                                                                                                                                                                                                                                            |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                                      | C. CITY OR TOWN<br><i>East Meadow</i>                                                                 |                                                            | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>                                                                                                                                                                                                                                       |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>                                                                                                         |                                      | E. STREET AND NUMBER<br><i>79 AYLWOOD DRIVE EAST MEADOW LONG</i>                                      |                                                            | F. STATE<br><i>ESTAD</i>                                                                      |                                                             |
| 5. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                               | 6. RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>7/10/1922</i> | 9. AGE (In years last birthday)<br><i>80</i>                                                          | 11. BIRTHPLACE (State or foreign country)<br><i>Russia</i> | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                    | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 13. FATHER'S NAME<br><i>Pesach Dubin</i>                                                                                                                                                                                                                                                                                                              |                         | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>                                                                                                                  |                                      | 17. INFORMANT<br><i>Brooklyn, New York 11218</i><br><i>Boulevard Chapels, 312 Coney Island Avenue</i> |                                                            |                                                                                               |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                                                 |                         | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                      | 17. INFORMANT<br><i>Brooklyn, New York 11218</i><br><i>Boulevard Chapels, 312 Coney Island Avenue</i> |                                                            |                                                                                               |                                                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, i.e., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>ACUTE MYOCARDIAL INFARCTION</i>                                                                                                              |                         | CAUSE OF DEATH                                                                                                                                              |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                          |                                                            |                                                                                               |                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) <i>Diabetes Mellitus</i><br>UNDERLYING CONDITION last.                                                                                                                                                                                                        |                         | (A) IMMEDIATE CAUSE<br><i>AS RENAL FAILURE &amp;</i><br>DUE TO, OR AS A CONSEQUENCE OF: <i>HYPERKALEMIA</i>                                                 |                                      |                                                                                                       |                                                            |                                                                                               |                                                             |
|                                                                                                                                                                                                                                                                                                                                                       |                         | (B) <i>PNEUMOTHORAX LT</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                               |                                      |                                                                                                       |                                                            |                                                                                               |                                                             |
|                                                                                                                                                                                                                                                                                                                                                       |                         | (C) <i>FRACTURE LT HIP</i>                                                                                                                                  |                                      |                                                                                                       |                                                            |                                                                                               |                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):<br><i>DIABETES MELLITUS</i>                                                                                                                                                                                    |                         |                                                                                                                                                             |                                      |                                                                                                       |                                                            |                                                                                               |                                                             |
| 19A. DATE OF OPERATION<br><i>8-22-72</i>                                                                                                                                                                                                                                                                                                              |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>FRACTURE LT HIP</i>                                                                                  |                                      | 20A. AUTOPSY? (Yes or No)<br><i>NO</i>                                                                |                                                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input checked="" type="checkbox"/>                                                                                                                                                                                                                          |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><i>Home</i>                                                     |                                      | 21C. WHERE DID INJURY OCCUR?<br><i>6512 WICKFIELD RD #09</i>                                          |                                                            | (If in Baltimore City, give exact location)                                                   |                                                             |
| 21D. TIME OF INJURY (APPROX.)<br><i>8-19-72</i>                                                                                                                                                                                                                                                                                                       |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                        |                                      | 21F. HOW DID INJURY OCCUR?<br><i>FALL DOWN on Kitchen Floor</i>                                       |                                                            |                                                                                               |                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-20</i> 19 <i>72</i> to <i>9-11</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>9-11</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                      |                                                                                                       |                                                            |                                                                                               |                                                             |
| 23A. SIGNATURE<br><i>Narong Sirisabya, M.D.</i>                                                                                                                                                                                                                                                                                                       |                         | 23B. DATE SIGNED<br><i>9-11-72</i>                                                                                                                          |                                      | 23C. PHYSICIAN'S NAME (Type)<br><i>NARONG SIRISABYA</i>                                               |                                                            |                                                                                               |                                                             |
| 23D. ADDRESS<br><i>SINAI HOSPITAL OF BALTIMORE</i>                                                                                                                                                                                                                                                                                                    |                         | 23E. DEGREE<br><i>M.D.</i>                                                                                                                                  |                                      | 23F. DEGREE<br><i>M.D.</i>                                                                            |                                                            |                                                                                               |                                                             |
| 24A. BURIAL CREMATION, (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                     |                         | 24B. DATE<br><i>9/11/1972</i>                                                                                                                               |                                      | 24C. NAME of CEMETERY or CREMATORY<br><i>United Hebrew</i>                                            |                                                            | 24D. LOCATION (City, town, or county) (State)<br><i>Staten Island, New York</i>               |                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 14 1972</i>                                                                                                                                                                                                                                                                                                 |                         | 25B. NAME OF REGISTRAR<br><i>Sol Levinson</i>                                                                                                               |                                      | 25C. FUNERAL DIRECTOR ADDRESS<br><i>76 Bros. 6010 Reisterstown Rd.</i>                                |                                                            |                                                                                               |                                                             |

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Thursdays

Brooklyn, New York 11218  
Hartford, Connecticut, 211 Conroy Island Avenue

Staten Island, New York

201 Madison Avenue, 2010 Rockefeller Plaza

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

| Baltimore City Health Department                                                                                                                                                               |  |                                                                                         |  | 12-08828                                                                                                                                                    |  | 72-08828                                                             |  | 12-08828                                                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| A-232                                                                                                                                                                                          |  |                                                                                         |  | 72-08828                                                                                                                                                    |  | 12-08828                                                             |  | 12-08828                                                                                      |  |
| BIRTH NO.                                                                                                                                                                                      |  |                                                                                         |  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |  | 2. DATE AND HOUR OF DEATH                                            |  | STATE OF MARYLAND - DEATH                                                                     |  |
|                                                                                                                                                                                                |  |                                                                                         |  | AGESTEIN YETTA                                                                                                                                              |  | 9 10-72                                                              |  | 7:55 a.m.                                                                                     |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                         |  |                                                                                         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY                                                 |  | C. CITY OR TOWN                                                      |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)                                                                                      |  |                                                                                         |  | MD BALTA                                                                                                                                                    |  | Balto                                                                |  | 2831                                                                                          |  |
| Sinai Hospital of Baltimore, Inc<br>Belvedere Ave at Greenspring                                                                                                                               |  |                                                                                         |  | E. STREET AND NUMBER                                                                                                                                        |  | 6610 Eberly Dr - apt 203                                             |  |                                                                                               |  |
| 5. SEX<br>FEMALE                                                                                                                                                                               |  | 6. RACE<br>WHITE                                                                        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>1-27-94                                          |  | 9. AGE (in years last birthday)<br>78                                                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                    |  |                                                                                         |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)                            |  | 12. CITIZEN OF WHAT COUNTRY?                                                                  |  |
| Housewife                                                                                                                                                                                      |  |                                                                                         |  | at Home                                                                                                                                                     |  | Poland                                                               |  | USA.                                                                                          |  |
| 13. FATHER'S NAME                                                                                                                                                                              |  |                                                                                         |  | 14. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                                                      |  |                                                                                               |  |
| Nathan Sugarman                                                                                                                                                                                |  |                                                                                         |  | Anna (Mikracon)                                                                                                                                             |  |                                                                      |  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                       |  |                                                                                         |  | 16. SOCIAL SECURITY NO.                                                                                                                                     |  | 17. INFORMANT                                                        |  |                                                                                               |  |
| No                                                                                                                                                                                             |  |                                                                                         |  | 219-30-5326                                                                                                                                                 |  | Elliott City, Md - ADDRESS<br>Milton Agestein - Wharff Lane          |  |                                                                                               |  |
| 18. CAUSE OF DEATH                                                                                                                                                                             |  |                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                      |  |                                                                                               |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  |                                                                                         |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |  |                                                                      |  | 8 hrs.                                                                                        |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                 |  |                                                                                         |  | (B) Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                          |  |                                                                      |  | 1 d                                                                                           |  |
| (C)                                                                                                                                                                                            |  |                                                                                         |  |                                                                                                                                                             |  |                                                                      |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                         |  |                                                                                         |  |                                                                                                                                                             |  |                                                                      |  |                                                                                               |  |
| 19A. DATE OF OPERATION                                                                                                                                                                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                        |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |  | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)                                                                                     |  |                                                                      |  |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                  |  | 21E. INJURY OCCURRED                                                                    |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                      |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9-10 1972 to 9-10 1972                                                                                                       |  | that (I) (we) last saw the deceased alive on 9-10 1972                                  |  | and that (in my) (our) opinion death occurred on the date                                                                                                   |  |                                                                      |  |                                                                                               |  |
| 23A. SIGNATURE                                                                                                                                                                                 |  | 23B. DATE SIGNED                                                                        |  | 23C. PHYSICIAN'S NAME (Type)                                                                                                                                |  | 23D. ADDRESS                                                         |  |                                                                                               |  |
| Dorothy Boonsue                                                                                                                                                                                |  | 9-10-72                                                                                 |  | SRISOUK BOONSUE                                                                                                                                             |  | MD Sinai Hosp. of Balto.                                             |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                       |  | 24B. DATE                                                                               |  | 24C. NAME of CEMETERY or CREMATORY                                                                                                                          |  | 24D. LOCATION (City, town, or county)                                |  | (State)                                                                                       |  |
| Burial                                                                                                                                                                                         |  | Sept 11/72                                                                              |  | Workmen Circle                                                                                                                                              |  | Baltimore, Maryland                                                  |  | (State)                                                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                |  | 25B. NAME OF REGISTRAR                                                                  |  | 25C. FUNERAL DIRECTOR                                                                                                                                       |  | ADDRESS                                                              |  |                                                                                               |  |
| SEP 14 1972                                                                                                                                                                                    |  | Dorothy Boonsue                                                                         |  | Sol Leonard                                                                                                                                                 |  | 2nd - 6010 Reisterstown Rd                                           |  |                                                                                               |  |

RECEIVED

ATTENTION

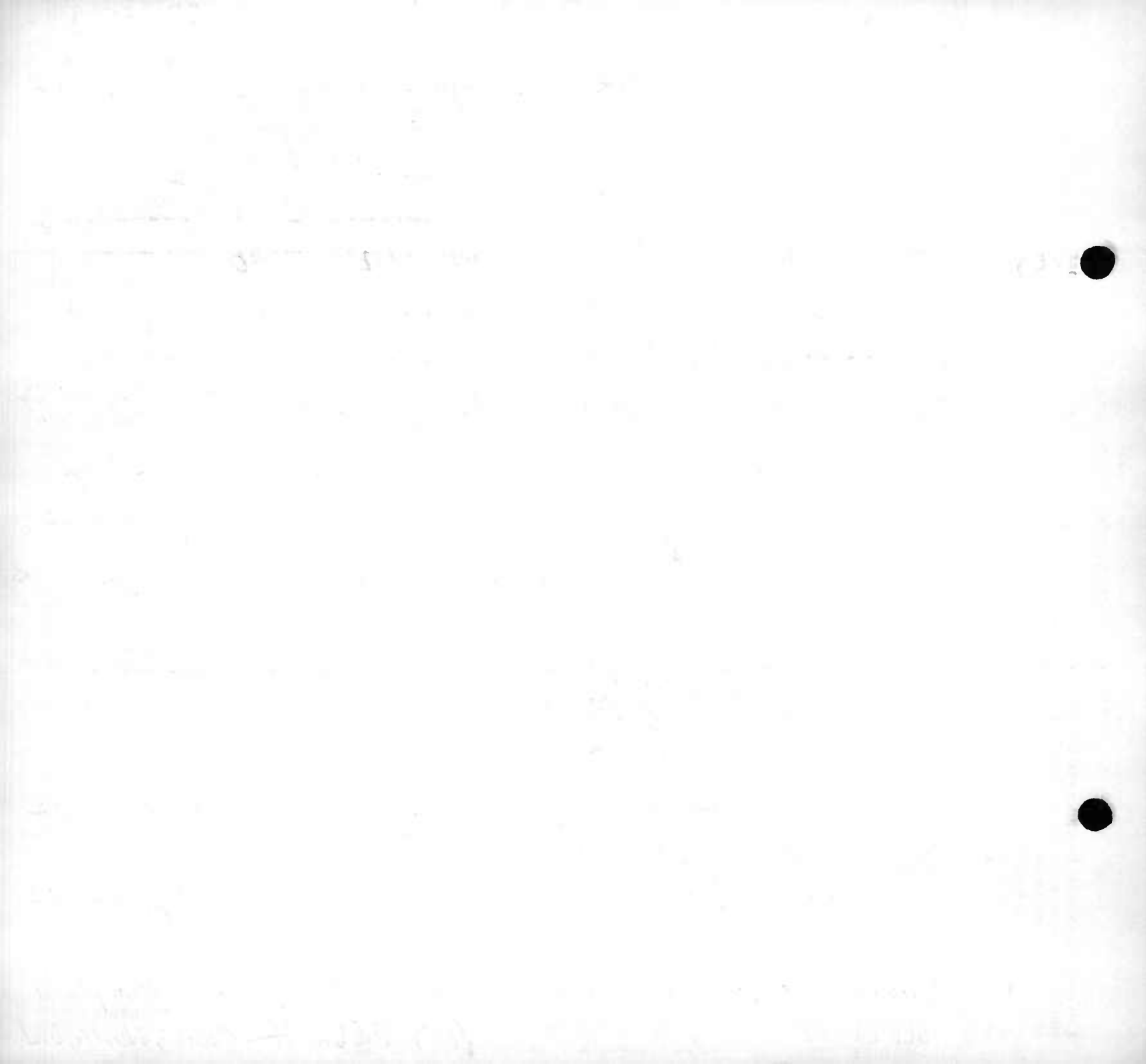
W



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |                              | REG. NO.                                                                 |                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                              | STATE OF MARYLAND-DEME                                                   |                                                        |
| S-140<br>BIRTH NO.                                                                                                                                                                                                                                                                                                  |                  | 72 08829                                                                                                                                                    |                              | 72 08829                                                                 |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                              |                  | SHIPLEY, CLARENCE Edgar J.                                                                                                                                  |                              | 2. DATE AND HOUR OF DEATH<br>9/12/72 2:15 A.M.                           |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                              |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                              |                                                                          |                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                        |                  | A. STATE B. COUNTY<br>M.D. Baltimore                                                                                                                        |                              |                                                                          |                                                        |
| SINAI HOSP. of BALTIMORE                                                                                                                                                                                                                                                                                            |                  | C. CITY OR TOWN Reisterstown D. INSIDE CITY LIMITS?<br>Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |                              |                                                                          |                                                        |
|                                                                                                                                                                                                                                                                                                                     |                  | E. STREET AND NUMBER 229 Bentley Hill Dr.<br>Belvedere of Green Spring                                                                                      |                              |                                                                          |                                                        |
| 5. SEX<br>M                                                                                                                                                                                                                                                                                                         | 6. RACE<br>Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>07/06/32 | 9. AGE (In years last birthday)<br>40                                    | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                         |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                              | 11. BIRTHPLACE (State or foreign country)                                |                                                        |
| Balti. Co. Fire Dept                                                                                                                                                                                                                                                                                                |                  | Fire Fighter                                                                                                                                                |                              | Baito., Maryland                                                         |                                                        |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                   |                  | 14. MOTHER'S MAIDEN NAME                                                                                                                                    |                              | 12. CITIZEN OF WHAT COUNTRY?                                             |                                                        |
| Clarence E. Shipley                                                                                                                                                                                                                                                                                                 |                  | Elizabeth L. Reeside                                                                                                                                        |                              | U. S. A.                                                                 |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                            |                  | 16. SOCIAL SECURITY NO.                                                                                                                                     |                              | 17. INFORMANT                                                            |                                                        |
| Yes Korean                                                                                                                                                                                                                                                                                                          |                  | 216-28-9536                                                                                                                                                 |                              | Nancy Shipley 229 Bentley Hill Dr. Reisterstown, Md.                     |                                                        |
| 18. 56941                                                                                                                                                                                                                                                                                                           |                  | CAUSE OF DEATH                                                                                                                                              |                              |                                                                          |                                                        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                      |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                         |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                                                        |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                         |                  | Septic Shock                                                                                                                                                |                              | 2 days                                                                   |                                                        |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                   |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                              | 3 wks.                                                                   |                                                        |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                           |                  | Acute Pan Peritonitis, Hepatic abscess                                                                                                                      |                              |                                                                          |                                                        |
|                                                                                                                                                                                                                                                                                                                     |                  | (C) Perforated ileum, Terminal ileitis                                                                                                                      |                              | 3 1/2 wks.                                                               |                                                        |
| II                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             |                              |                                                                          |                                                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                    |                  |                                                                                                                                                             |                              |                                                                          |                                                        |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                              | 20A. AUTOPSY? (Yes or No)                                                |                                                        |
| 108/28/72                                                                                                                                                                                                                                                                                                           |                  | Perforated ileum                                                                                                                                            |                              |                                                                          |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                               |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                        |
|                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                              |                                                                          |                                                        |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                       |                  | 21E. INJURY OCCURRED                                                                                                                                        |                              | 21F. HOW DID INJURY OCCUR?                                               |                                                        |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                         |                  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                           |                              |                                                                          |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 12/19 72 to Sept 12 19 72 that (I) (we) last saw the deceased alive on Sept 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                              |                                                                          |                                                        |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |                              | 23B. DATE SIGNED                                                         |                                                        |
| J. J. J. J. J. J. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                                                                                              |                  |                                                                                                                                                             |                              | Sept. 12 72                                                              |                                                        |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                              | 23D. ADDRESS                                                             |                                                        |
|                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                              |                                                                          |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                            |                  | 24B. DATE                                                                                                                                                   |                              | 24C. NAME of CEMETERY or CREMATORY                                       |                                                        |
| Burial                                                                                                                                                                                                                                                                                                              |                  | 9/14/72                                                                                                                                                     |                              | Moreland Mem. Park                                                       |                                                        |
|                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                              | Baltimore, Maryland.                                                     |                                                        |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                     |                  | 25B. NAME OF REGISTRAR                                                                                                                                      |                              | 25C. FUNERAL DIRECTOR                                                    |                                                        |
| SEP 14 1972                                                                                                                                                                                                                                                                                                         |                  | Anthony J. J. J. J.                                                                                                                                         |                              | Owingskills, Md.                                                         |                                                        |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                                                                                                                                                  |                                    |                                                                                               |                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                 |                         | 72 08830                                                                                                                                                                                                                                                                         |                                    | REG. NO.                                                                                      |                                                               |
| W-230                                                                                                                                                                                                                                                                                                                                                            |                         | 72 08830                                                                                                                                                                                                                                                                         |                                    | 72 08830                                                                                      |                                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                        |                         | 72 08830                                                                                                                                                                                                                                                                         |                                    | STATE OF MARYLAND-DEMH                                                                        |                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Nannie West.</u>                                                                                                                                                                                                                                                                                                       |                         | 2. DATE AND HOUR OF DEATH<br><u>9/13/72</u> <u>4.15</u> M.                                                                                                                                                                                                                       |                                    |                                                                                               |                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><u>Montebello Hosp.</u>                                                                                                                                                                                                                                                                            |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>                                                                                                                                     |                                    |                                                                                               |                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>91</u>                                                                                                                                                                                                                                                                                                                |                         | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                                                                                                                              |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                               |
|                                                                                                                                                                                                                                                                                                                                                                  |                         | E. STREET AND NUMBER<br><u>1126 Woodyear St.</u>                                                                                                                                                                                                                                 |                                    |                                                                                               |                                                               |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                          | 6. RACE<br><u>Black</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                      | 8. DATE OF BIRTH<br><u>6/22/94</u> | 9. AGE (In years last birthday)<br><u>78</u>                                                  | 10. If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>                                                                                                                                                                                                                                    |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>                                       |                                                               |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>                                                                                                                                                                                                                                                                                                                      |                         | 13. FATHER'S NAME<br><u>James Tilghman</u>                                                                                                                                                                                                                                       |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Betty Ware</u>                                                 |                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)<br><u>no</u>                                                                                                                                                                                                                                            |                         | 16. SOCIAL SECURITY NO.<br><u>212 2611 77</u>                                                                                                                                                                                                                                    |                                    | 17. INFORMANT<br><u>Helen Ware</u> same ADDRESS                                               |                                                               |
| 18. <u>412.2 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST          |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Pulmonary embolism</u><br><br>(B) <u>middle cerebral artery thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>hypertensive cardio vascular disease</u><br><br>(C) <u>hypertensive cardio vascular disease</u> |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>over 1 year</u>                            |                                                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                 |                         |                                                                                                                                                                                                                                                                                  |                                    |                                                                                               |                                                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                 |                                    | 20A. AUTOPSY? (Yes or No)<br><u>no</u>                                                        |                                                               |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                                                                                                                                                  |                                    |                                                                                               |                                                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                          |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                         |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                        |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                        |                                    | 21F. HOW DID INJURY OCCUR?                                                                    |                                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 22</u> 19 <u>71</u> to <u>Sept. 13</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Sept. 13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                                                                                                                                                  |                                    |                                                                                               |                                                               |
| 23A. SIGNATURE<br><u>Cesar L. Gonzalez C.M.D.</u>                                                                                                                                                                                                                                                                                                                |                         | 23B. DATE SIGNED<br><u>9/13/72</u>                                                                                                                                                                                                                                               |                                    |                                                                                               |                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Cesar L. Gonzalez C.M.D.</u>                                                                                                                                                                                                                                                                                                  |                         | 23D. ADDRESS<br><u>1015 Halstead Rd #2, Balto Md.</u>                                                                                                                                                                                                                            |                                    |                                                                                               |                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                        |                         | 24B. DATE<br><u>9-16-72</u>                                                                                                                                                                                                                                                      |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Memorial Park</u>                            |                                                               |
| 24D. LOCATION<br><u>Baltimore, Md.</u>                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                                                                                                                                                  |                                    |                                                                                               |                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 14 1972</u>                                                                                                                                                                                                                                                                                                            |                         | 25B. NAME OF REGISTRAR<br><u>Sidney</u>                                                                                                                                                                                                                                          |                                    | 25C. FUNERAL DIRECTOR<br><u>V. Bailey</u> ADDRESS<br><u>1348 Calhoun Street</u>               |                                                               |

97

MP/21.3

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08831

BIRTH NO.

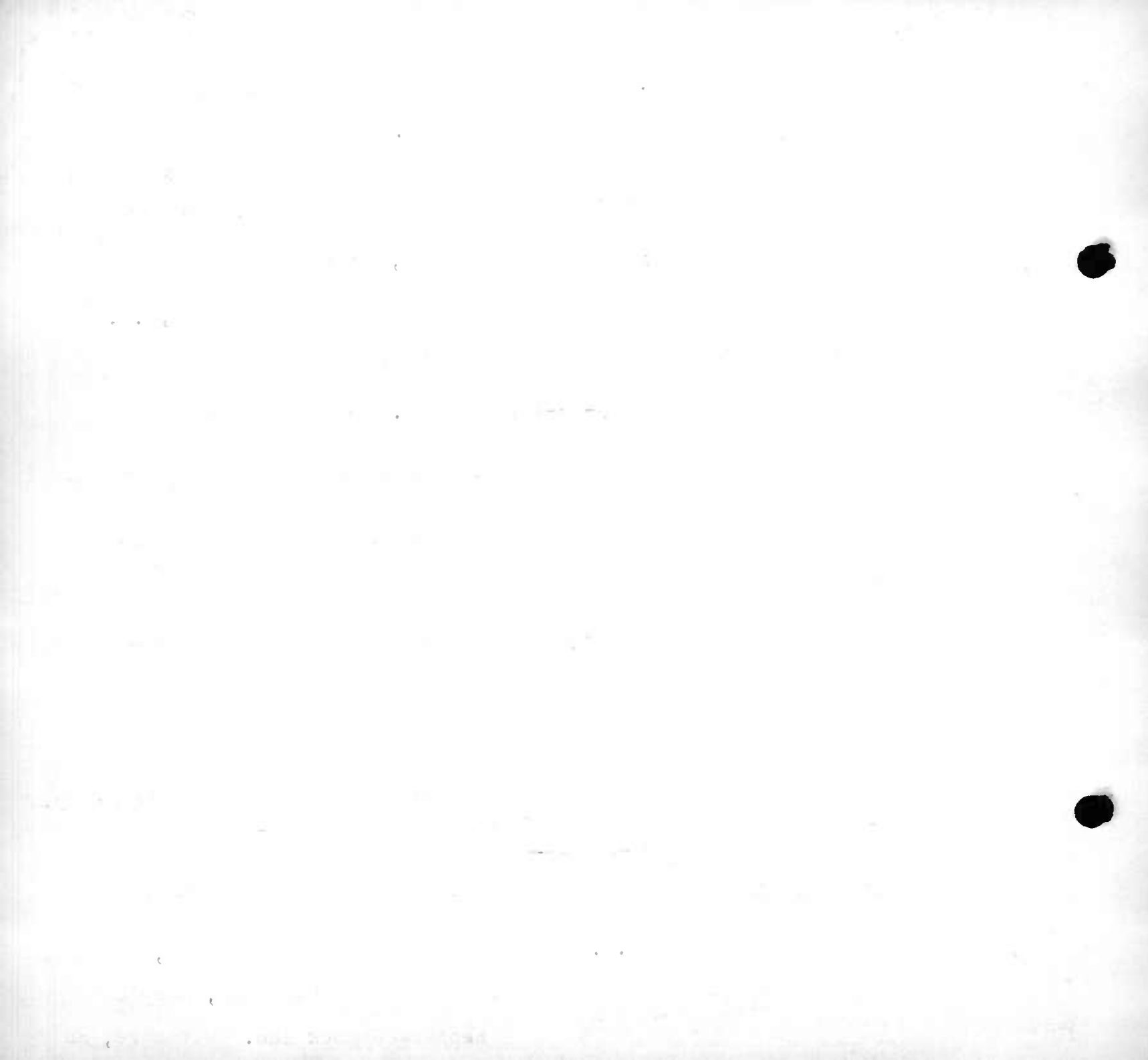
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>FRED ALLEN, JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> <b>September 12, 1972</b> M. |  |                                                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL (DOA)</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 12, 1972 4:12 P.M.</b>                                                                |  |                                                                             |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>806</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                         |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                        |  |                                                                             |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 7. RACE<br><b>Negro</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | E. STREET AND NUMBER<br><b>1815 N. Chapel Street</b>                                                                                                 |  |                                                                             |  |
| 9. DATE OF BIRTH<br><b>7-3-60</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 10. AGE (In years lost birthday)<br><b>12</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                                     |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                              |  |                                                                             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 13. FATHER'S NAME<br><b>Arthur Allen</b>                                                                                                                    |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>student</b>                                         |  |                                                                             |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Mary Lee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                        |  | 17. SOCIAL SECURITY NO.<br><b>---</b>                                                                                                                |  | 18. INFORMANT ADDRESS<br><b>Arthur Allen same</b>                           |  |
| 19. CAUSE OF DEATH<br><b>Gunshot wound of chest</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                  |                         |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                         |  |                                                                             |  |
| 20A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                                                                      |  | 21. AUTOPSY? (Yes or No)<br><b>no</b>                                       |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 22B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)<br><b>House</b>                                                    |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>1816 N. Chapel Street, 2nd floor</b>                                  |  |                                                                             |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>9-12-72 3:20 P.M.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                           |  | 22F. HOW DID INJURY OCCUR?<br><b>Shot while playing with gun</b>                                                                                     |  |                                                                             |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b><br>EXAMINER'S NAME (Type)<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>9/13/72</b> |                         |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 24B. DATE<br><b>9-16-72</b>                                                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore Cemetery</b>                                                                                      |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 25B. NAME OF REGISTRAR<br><b>Ardrey H. Weston</b>                                                                                                           |  | 25C. FUNERAL DIRECTOR V. Bailey ADDRESS<br><b>Kelson F.H. 1348 Calhoun Street</b>                                                                    |  |                                                                             |  |

*Stylized signature*  
Vector, L. 100, 100, 100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                             |  |                                                                                                                                  |  | REG. NO.                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                    |  | 72 08832                                                                                                                         |  | 72 08832                                                                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                       |  | 2. DATE AND HOUR OF DEATH                                                                                                        |  |                                                                                            |  |
| CATHERINE M. BAUER                                                                                                                           |  | 9/12/72 1:40 P.M.                                                                                                                |  |                                                                                            |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)                                             |  |                                                                                            |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                 |  | A. STATE                                                                                                                         |  | B. COUNTY                                                                                  |  |
| 90 Gould Convalesarium                                                                                                                       |  | Md.                                                                                                                              |  | 2641                                                                                       |  |
| 5. SEX                                                                                                                                       |  | 6. RACE                                                                                                                          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                 |  |
| Female                                                                                                                                       |  | White                                                                                                                            |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>              |  |
| 8. DATE OF BIRTH                                                                                                                             |  | 9. AGE (in years last birthday)                                                                                                  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |
| July 11, 1881                                                                                                                                |  | 91                                                                                                                               |  | Housewife                                                                                  |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                    |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                     |  | 13. FATHER'S NAME                                                                          |  |
| Maryland                                                                                                                                     |  | U.S.A.                                                                                                                           |  | Henry Berger                                                                               |  |
| 14. MOTHER'S MAIDEN NAME                                                                                                                     |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                         |  | 16. SOCIAL SECURITY NO.                                                                    |  |
| Catherine Coomes                                                                                                                             |  | No                                                                                                                               |  | 215-03-1776D                                                                               |  |
| 17. INFORMANT                                                                                                                                |  | 18. CAUSE OF DEATH                                                                                                               |  | ADDRESS                                                                                    |  |
| Mr H. Wacker                                                                                                                                 |  | Same                                                                                                                             |  | Same                                                                                       |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                           |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                               |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  | Antisclerotic Heart Disease                                                                                                      |  | —                                                                                          |  |
| ANTECEDENT CAUSES                                                                                                                            |  | (B) Chronic Antisclerotic                                                                                                        |  | years                                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |  | (C)                                                                                                                              |  | —                                                                                          |  |
| II                                                                                                                                           |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | Hypertension; Urinary Tract Infection; Arteriosclerosis                                    |  |
| 19A. DATE OF OPERATION                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20A. AUTOPSY? (Yes or No)                                                                  |  |
| —                                                                                                                                            |  | —                                                                                                                                |  | —                                                                                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                         |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                |  | 21E. INJURY OCCURRED                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                                 |  |
| (Month) (Day) (Year) (Hour)                                                                                                                  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                |  | —                                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from                                                                            |  | 8/5/72                                                                                                                           |  | 9/12/72                                                                                    |  |
| that (I) (we) last saw the deceased alive on                                                                                                 |  | 9/6/1972                                                                                                                         |  | and that in (my) (our) opinion death occurred on the date                                  |  |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                               |  | 23A. SIGNATURE                                                                                                                   |  | 23B. DATE SIGNED                                                                           |  |
| Albert B Bradley                                                                                                                             |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |  | 9/12/72                                                                                    |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                 |  | 23D. ADDRESS                                                                                                                     |  | 24A. BURIAL CREMATION, REMOVAL (Specify)                                                   |  |
| Albert B Bradley M.D.                                                                                                                        |  | 4900 Belair Rd Baltimore, Maryland                                                                                               |  | Burial                                                                                     |  |
| 24B. DATE                                                                                                                                    |  | 24C. NAME OF CEMETERY OR CREMATORY                                                                                               |  | 24D. LOCATION (City, town, or county) (State)                                              |  |
| 9/15/72                                                                                                                                      |  | Jerusalem Lutheran                                                                                                               |  | Baltimore, Maryland                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                              |  | 25B. NAME OF REGISTRAR                                                                                                           |  | 25C. FUNERAL DIRECTOR                                                                      |  |
| SEP 14 1972                                                                                                                                  |  | Leonard J. Ruck Inc.                                                                                                             |  | Baltimore, Md                                                                              |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>B-634</span> <span>72 08833</span> </div> <h2 style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT<br/>CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REG. NO. 72 08833</span> <span>STATE OF MARYLAND - DEPT</span> </div>                                                         |                             |                                                                                                                                                             |                                                                        |
| 1. NAME OF DECEASED<br>(Type or) <b>M. Loretta Bartolomeo</b>                                                                                                                                                                                                                                                                                                                                                |                             | 2. DATE AND HOUR OF DEATH<br><b>9-12-72 18<sup>03</sup> A.M.</b>                                                                                            |                                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>HAMILTON NURSING CENTER<br/>90 HARFORD RD. HAMILTON</b>                                                                                                                                                                        |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b>                        |                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                              |                             | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                              |                             | E. STREET AND NUMBER <b>4908 Arabia Ave.</b>                                                                                                                |                                                                        |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE <b>W</b>            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2-20-1900</b>                                      |
| 9. AGE (In years last birthday) <b>72</b>                                                                                                                                                                                                                                                                                                                                                                    |                             | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                               |                                                                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                              |                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                        |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                |                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |                                                                        |
| 13. FATHER'S NAME<br><b>Patrick McMamara</b>                                                                                                                                                                                                                                                                                                                                                                 |                             | 14. MOTHER'S MAIDEN NAME<br><b>Anastasia Walsh</b>                                                                                                          |                                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                        |                             | 16. SOCIAL SECURITY NO.<br><b>217-01-5833</b>                                                                                                               |                                                                        |
| 17. INFORMANT<br><b>John P. Bartolomeo</b>                                                                                                                                                                                                                                                                                                                                                                   |                             | ADDRESS<br><b>5113 Hillburn Ave. 21216</b>                                                                                                                  |                                                                        |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinomatous</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Carcinoma of Uterus</b> |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>                                                                                             |                                                                        |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                             |                             |                                                                                                                                                             |                                                                        |
| 19A. DATE OF OPERATION <b>9-11-72</b>                                                                                                                                                                                                                                                                                                                                                                        |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                        |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                    |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |                                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                        |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                        |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             |                                                                        |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                    |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                        |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                   |                             |                                                                                                                                                             |                                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 19 1972</b> to <b>Sept 12 1972</b> , that (I) (we) last saw the deceased alive on <b>9-11 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                       |                             |                                                                                                                                                             |                                                                        |
| 23A. SIGNATURE<br><b>Harold H Burns M.D. FACS</b>                                                                                                                                                                                                                                                                                                                                                            |                             | 23B. DATE SIGNED<br><b>9-12-1972</b>                                                                                                                        |                                                                        |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Harold H. Burns, M.D.</b>                                                                                                                                                                                                                                                                                                                                                 |                             | 23D. ADDRESS<br><b>8106 Harford Rd. Baltimore MD 34</b>                                                                                                     |                                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                    | 24B. DATE<br><b>9/15/72</b> | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                                                                                                  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                        |                             | 25B. NAME OF REGISTRAR<br><b>Leonard J. Ruck, Inc.</b>                                                                                                      |                                                                        |
| 25C. FUNERAL DIRECTOR<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                  |                             | ADDRESS                                                                                                                                                     |                                                                        |

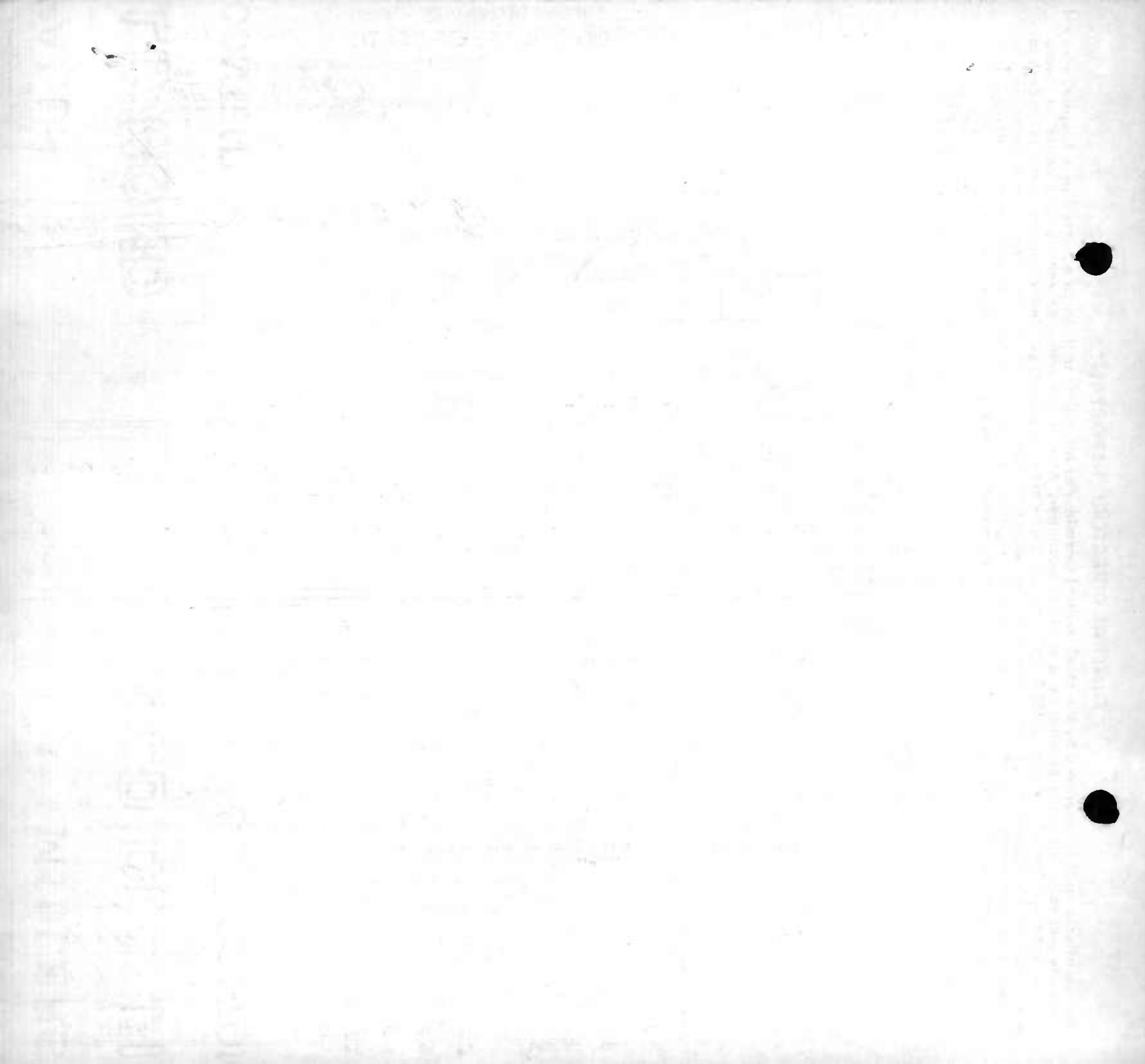




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                       |  |                                                                                                                    |  | REG. NO. 72 08834                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 72 08834 STATE OF MARYLAND - DEPT. OF HEALTH CERTIFICATE OF DEATH                                                                                                                                                                                                                                      |  |                                                                                                                    |  |                                                                                                                                                          |  |
| BIRTH NO. 72 08834                                                                                                                                                                                                                                                                                     |  | 2. DATE AND HOUR OF DEATH 9/8/72 11:00 AM                                                                          |  |                                                                                                                                                          |  |
| 1. NAME OF DECEASED (Type or Print) Coit James                                                                                                                                                                                                                                                         |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                             |  |                                                                                                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                   |  | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                 |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                                                    |  |
| South Baltimore Gen. Hosp.                                                                                                                                                                                                                                                                             |  | 2944 CARLEE RD                                                                                                     |  | A. STATE B. COUNTY                                                                                                                                       |  |
| 5. SEX Male                                                                                                                                                                                                                                                                                            |  | 6. RACE White                                                                                                      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH 4-7                                                                                                                                                                                                                                                                                   |  | 9. AGE (In years last birthday) 47                                                                                 |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed                                                    |  |
| 11. BIRTHPLACE (State or foreign country) Conway S C                                                                                                                                                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY U S A                                                                                  |  | 13. FATHER'S NAME Ike Coit                                                                                                                               |  |
| 14. MOTHER'S MAIDEN NAME Mamie                                                                                                                                                                                                                                                                         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 2 |  | 16. SOCIAL SECURITY NO. 238-32-4915                                                                                                                      |  |
| 17. INFORMANT Mrs Carrie Coit, Same                                                                                                                                                                                                                                                                    |  | ADDRESS                                                                                                            |  | 18. CAUSE OF DEATH                                                                                                                                       |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                         |  | ANTECEDENT CAUSES                                                                                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                           |  | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.          |  | Chronic debilitation & Respiratory distress 1 month                                                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                       |  | multiple intra abdominal abscesses                                                                                 |  | 2 weeks                                                                                                                                                  |  |
| 19A. DATE OF OPERATION 9/4/72                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Door                                                              |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                           |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                        |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>             |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 5/20 1972 to 9/8 1972 that (I) (we) last saw the deceased alive on 9/8 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                    |  |                                                                                                                                                          |  |
| 23A. SIGNATURE J. HAN. M.D.                                                                                                                                                                                                                                                                            |  | 23B. DATE SIGNED 9/8/72                                                                                            |  | 23C. PHYSICIAN'S NAME (Type) J. HAN. M.D.                                                                                                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                        |  | 24B. DATE 9/16/72                                                                                                  |  | 24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery                                                                                                    |  |
| 24D. LOCATION Baltimore, MD                                                                                                                                                                                                                                                                            |  | 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1972                                                                        |  | 25B. NAME OF REGISTRAR Adolphus Halstead                                                                                                                 |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                  |  | 25D. ADDRESS                                                                                                       |  | 1206 W North Ave                                                                                                                                         |  |



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72 08835 STATE OF MARYLAND-DEMH  
BALTIMORE CITY HEALTH DEPARTMENT

S-200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 08835

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                     |                                                                                                                                                  |  |                                                                                               |     |                                                            |                                 |    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|-----|------------------------------------------------------------|---------------------------------|----|
| 1. NAME OF DECEASED<br>(Type or Print) DAVID E. SUGG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/>                                                            |  | Month                                                                                         | Day | Year                                                       | Hour                            | M. |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>00 339 Bloom Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                     | 3. DATE PRONOUNCED DEAD<br>September 12, 1972 12:45 A.M.                                                                                         |  | Month                                                                                         | Day | Year                                                       | Hour                            | M. |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1403                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                     | C. CITY OR TOWN<br>Baltimore                                                                                                                     |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |     |                                                            |                                 |    |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 7. RACE<br>Negro                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | E. STREET AND NUMBER<br>339 Bloom Street                                                      |     |                                                            |                                 |    |
| 9. DATE OF BIRTH<br>May 9-1931                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10. AGE (In years last birthday) 41 | 11. BIRTHPLACE (State or foreign country)<br>South Boston VA                                                                                     |  | 12. CITIZEN OF<br>USA                                                                         |     | 13. FATHER'S NAME<br>Charles F. Sugg                       |                                 |    |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Lawyer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                     | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                |  | 15. MOTHER'S MAIDEN NAME<br>Frances Poindexter                                                |     |                                                            |                                 |    |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes Korea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     | 17. SOCIAL SECURITY NO.<br>224-283162                                                                                                            |  | 18. INFORMANT ADDRESS<br>Francis Robbins 339 Bloom St                                         |     |                                                            |                                 |    |
| 19. 571.8<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Fatty metamorphosis of liver<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                |                                     | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |     |                                                            |                                 |    |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |  |                                                                                               |     |                                                            | 21. AUTOPSY? (Yes or No)<br>yes |    |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                     | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                      |     |                                                            |                                 |    |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                     | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                        |  | 22F. HOW DID INJURY OCCUR?                                                                    |     |                                                            |                                 |    |
| 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.<br>DATE SIGNED 9/12/72 |                                     |                                                                                                                                                  |  |                                                                                               |     |                                                            |                                 |    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                     | 24B. DATE<br>9/14/72                                                                                                                             |  | 24C. NAME OF CEMETERY or CREMATORY<br>Mt Auburn                                               |     | 24D. LOCATION (City, town, or county) (State)<br>Baltimore |                                 |    |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 14 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                     | 25B. NAME OF REGISTRAR<br>Sidney Houston                                                                                                         |  | 25C. FUNERAL DIRECTOR<br>Joseph P. Rogers                                                     |     | ADDRESS<br>6382 Gilman St                                  |                                 |    |

VS 151-REV. 1/1/68



1

B-650

72 08836

STATE OF MARYLAND

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08836

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>GEORGE M. BROWN Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> <b>September 8, 1972</b>                 |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>35 CHURCH HOME AND HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 8, 1972 7:15 P.M.</b>                                                                        |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>702</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7. RACE<br><b>Negro</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>1-27-54</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 10. AGE (In years last birthday) <b>18</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                                        |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 17. SOCIAL SECURITY NO.                                                                                                                                     |  |
| 15. FATHER'S NAME<br><b>George Brown Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 15. MOTHER'S MAIDEN NAME<br><b>Williebulk Satterfield</b>                                                                                                   |  |
| 18. INFORMANT<br><b>George Brown Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | ADDRESS<br><b>800 N. Milton Ave</b>                                                                                                                         |  |
| 19. CAUSE OF DEATH<br><b>E 9651 X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                              |                         | CAUSE OF DEATH<br><b>Gunshot wound of chest</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B)<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C)  |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>House</b>                                                    |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>1101 Orleans Street, Apt. 1A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 22F. HOW DID INJURY OCCUR?<br><b>Shot during assault</b>                                                                                                    |  |
| 22D. TIME OF INJURY (APPROX.)<br><b>9-8-72 6:58 P.M.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                           |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>9/9/72</b> |                         |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 24B. DATE<br><b>9-13-72</b>                                                                                                                                 |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Arbutus Memorial Park</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Arbutus, Md.</b>                                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 14 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 25B. NAME OF REGISTRAR<br><b>Sidney [Signature]</b>                                                                                                         |  |
| 25C. FUNERAL DIRECTOR<br><b>Elliott Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | ADDRESS<br><b>1129 N. Caroline St.</b>                                                                                                                      |  |

VS 151-REV. 1/1/68

75

75

X

George Brown

U2A

1-1-24

MD

George Brown

William S. Smith

Labork

MD

George Brown

George Brown

MD

George Brown

MD

75

George Brown

George Brown

George Brown



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                                                                                               |                                                                                       |                            |                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------|--|
| H-400                                                                                                                                                                                                                                                                                                                                                 |                      | 72 08837                                                                                                                                                    |                                                                                                                                                                                               | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                            | 72 08837                                                                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |                                                                                                                                                                                               | CERTIFICATE OF DEATH                                                                  |                            |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Hull Gloria</i>                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |                                                                                                                                                                                               | 2. DATE AND HOUR OF DEATH<br><i>Sept 9 1972 5:05 A.M.</i>                             |                            |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             |                                                                                                                                                                                               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                            |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Johns Hopkins Hospital</i>                                                                                                                                                                                                                                                                                 |                      | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                                                                                                                                                                                               | A. STATE<br><i>Maryland</i>                                                           |                            | B. COUNTY<br><i>MONT.</i>                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                                                                                               | C. CITY OR TOWN<br><i>Silver Spring</i>                                               |                            | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                                                                                               | E. STREET AND NUMBER<br><i>900 E. Randolph St</i>                                     |                            |                                                                                               |  |
| 5. SEX<br><i>F</i>                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><i>C.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>2-23-34</i>                                                                                                                                                            | 9. AGE (in years last birthday)<br><i>38</i>                                          | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.                                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Teacher</i>                                                                                                                                                                                                                                         |                      |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                             |                                                                                       |                            | 11. BIRTHPLACE (State or foreign country)<br><i>North Carolina</i>                            |  |
| 12. CITIZEN OF WHAT COUNTRY<br><i>USA</i>                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             | 13. FATHER'S NAME<br><i>EDWARD HOUSE</i>                                                                                                                                                      |                                                                                       |                            | 14. MOTHER'S MAIDEN NAME<br><i>CLEOPATRA PEOPLES</i>                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                              |                      |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><i>191-30-2750</i>                                                                                                                                                 |                                                                                       |                            | 17. INFORMANT<br><i>Bernard Hull-husband-900 East Randolph</i>                                |  |
| 18. <i>15301</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                      |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>TERMINAL CA of OVERY one year</i><br>(B) <i>HEMATURIA</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <i>ANEMIA</i> |                                                                                       |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                |                      |                                                                                                                                                             |                                                                                                                                                                                               |                                                                                       |                            |                                                                                               |  |
| 19A. DATE OF OPERATION<br><i>0</i>                                                                                                                                                                                                                                                                                                                    |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                               | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                                |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                               |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                               | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)           |                            |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                          |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                               | 21F. HOW DID INJURY OCCUR?                                                            |                            |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/24/72</i> 19 <i>72</i> to <i>9/9</i> 19 <i>72</i><br>that (we) last saw the deceased alive on <i>8/9</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |                                                                                                                                                             |                                                                                                                                                                                               |                                                                                       |                            |                                                                                               |  |
| 23A. SIGNATURE<br><i>Youssef</i>                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                                                                                                                                                                               | 23B. DATE SIGNED<br><i>9/9/1972</i>                                                   |                            |                                                                                               |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>YOUSSEF YOUSSEF M.D.</i>                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             |                                                                                                                                                                                               | 23D. ADDRESS<br><i>THE JOHNS HOPKINS HOSPITAL</i>                                     |                            |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                             |                      | 24B. DATE<br><i>9/13/72</i>                                                                                                                                 |                                                                                                                                                                                               | 24C. NAME of CEMETERY or CREMATORY<br><i>Parklawn Cemetery</i>                        |                            | 24D. LOCATION (City, town, or county) (State)<br><i>Silver Spring, Maryland</i>               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 14 1972</i>                                                                                                                                                                                                                                                                                                 |                      | 25B. NAME OF REGISTRAR<br><i>Stewart Funeral Home</i>                                                                                                       |                                                                                                                                                                                               | 25C. FUNERAL DIRECTOR<br><i>Stewart Funeral Home-4001 Benning Rd</i>                  |                            |                                                                                               |  |

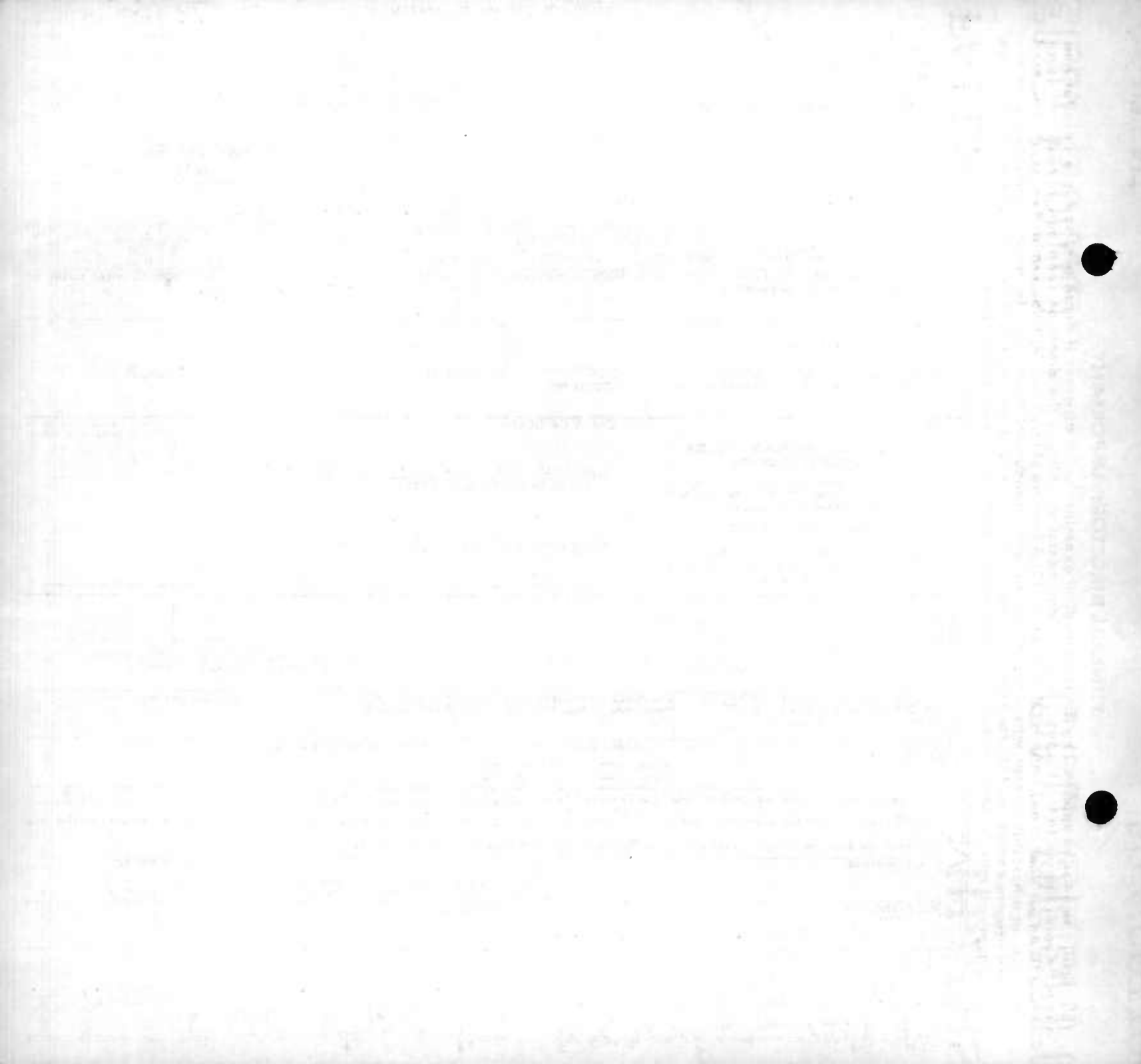




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

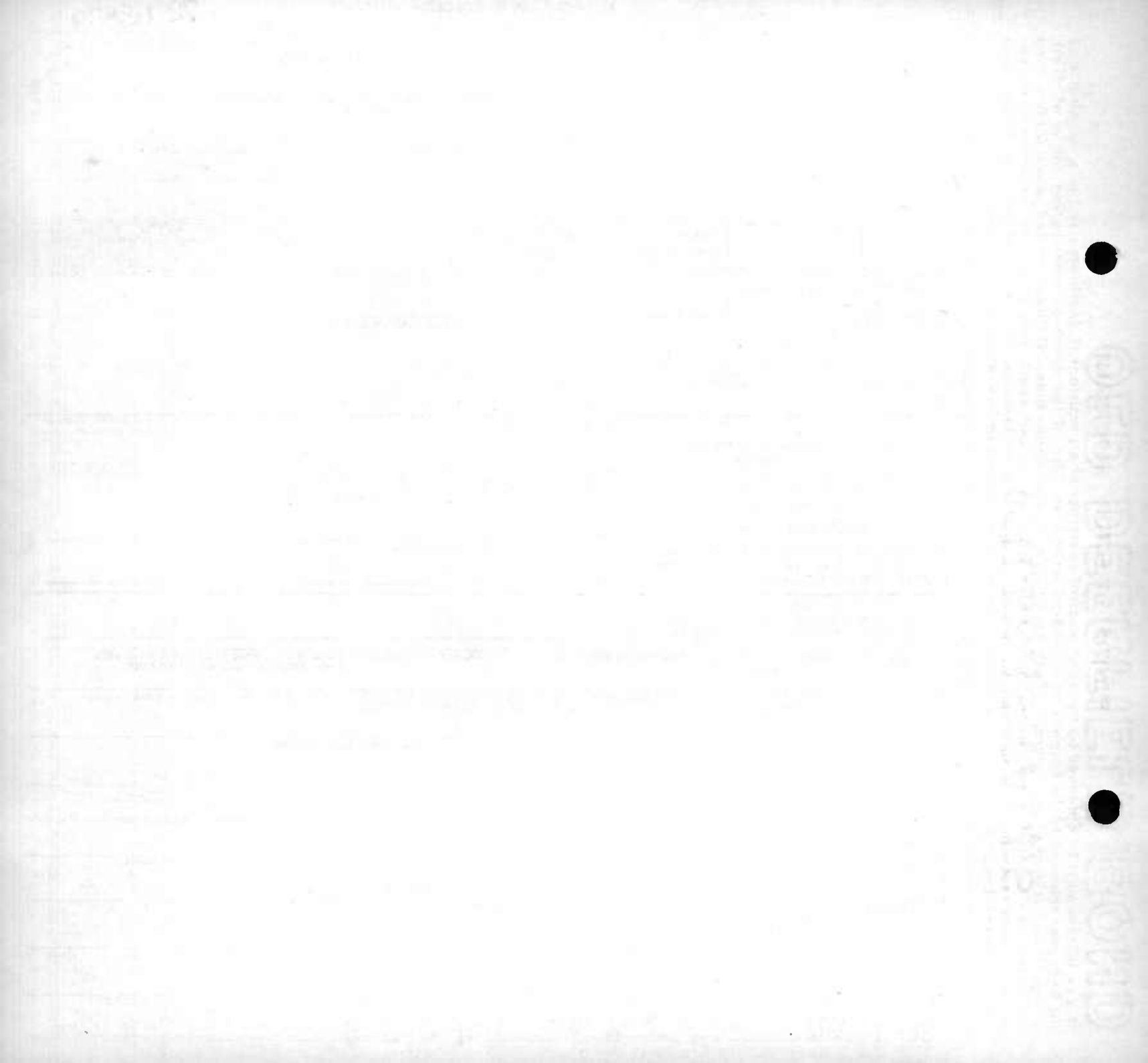
|                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |  |                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 72 08838                                                                                                                                                                                                                                                                                                          |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                  |  | REG. NO. 72 08838                                                                                                                                        |  |
| 5-363 72 08838                                                                                                                                                                                                                                                                                                    |  | 12-13456                                                                                                                          |  | CERTIFICATE OF DEATH                                                                                                                                     |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                            |  | 2. DATE AND HOUR OF DEATH                                                                                                         |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                   |  |
| BABY Girl Stewart                                                                                                                                                                                                                                                                                                 |  | Sept 12, 1972 4:45 P.M.                                                                                                           |  | FULL NAME OF HOSPITAL OR INSTITUTION<br>(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                             |  |
| The Johns Hopkins Hospital                                                                                                                                                                                                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                            |  |
| 5. SEX Female                                                                                                                                                                                                                                                                                                     |  | 6. RACE Negro                                                                                                                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH 9/10/72                                                                                                                                                                                                                                                                                          |  | 9. AGE (In years last birthday) 2                                                                                                 |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                               |  |
| 11. BIRTHPLACE (State or foreign country) Balto., Maryland                                                                                                                                                                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                      |  | 13. FATHER'S NAME Robert Stewart                                                                                                                         |  |
| 14. MOTHER'S MAIDEN NAME Phyllis Williams                                                                                                                                                                                                                                                                         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                          |  | 16. SOCIAL SECURITY NO.                                                                                                                                  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                     |  | ADDRESS                                                                                                                           |  |                                                                                                                                                          |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                      |  |                                                                                                                                                          |  |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure                                                                                                                                                                                                                                           |  | 5 hrs.                                                                                                                            |  |                                                                                                                                                          |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF: Hyaline Membrane Disease                                                                                                                                                                                                                                                      |  | 48 hrs.                                                                                                                           |  |                                                                                                                                                          |  |
| (C) Extreme Prematurity                                                                                                                                                                                                                                                                                           |  |                                                                                                                                   |  |                                                                                                                                                          |  |
| 19. DATE OF OPERATION                                                                                                                                                                                                                                                                                             |  | 19A. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |  | 20A. AUTOPSY? (Yes or No) Yes                                                                                                                            |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                          |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                         |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 10 1972 to Sept 12 1972 that (I) (we) last saw the deceased alive on Sept 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                   |  |                                                                                                                                                          |  |
| 23A. SIGNATURE J.E. Graeber MD                                                                                                                                                                                                                                                                                    |  | 23B. DATE SIGNED 9/12/72                                                                                                          |  | 23C. PHYSICIAN'S NAME (Type) Janet E. Graeber, M.D.                                                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation                                                                                                                                                                                                                                                                |  | 24B. DATE 9/13/72                                                                                                                 |  | 24C. NAME of CEMETERY or CREMATORY Johns Hopkins Hospital                                                                                                |  |
| 24D. LOCATION 601 N. Broadway Balto., Md.                                                                                                                                                                                                                                                                         |  | 25A. DATE REC'D BY HEALTH DEPT. SEP 14 1972                                                                                       |  | 25B. NAME OF REGISTRAR Sidney A. [Signature]                                                                                                             |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                             |  | 25D. HOSPITAL DISPOSAL                                                                                                            |  |                                                                                                                                                          |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                                                                                                                                  |                                    | REG. NO.                                                                        | 72 08839                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------|
| B-650 72 08839                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                                                                                                                                  |                                    | STATE OF MARYLAND-DEHE                                                          |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Brown, Wade M.</u>                                                                                                                                                                                                                                                                                          |                      | 2. DATE AND HOUR OF DEATH<br><u>9/12/72</u> <u>9<sup>20</sup></u> <u>A.M.</u>                                                                                                                                                                                    |                                    |                                                                                 |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>Balti.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                    |                                                                                 |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Bon Secours Hospital</u><br><u>Baltimore, Md.</u>                                                                                                                                                                                     |                      | E. STREET AND NUMBER<br><u>1935 W. Baltimore St.</u>                                                                                                                                                                                                             |                                    |                                                                                 |                                                           |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <u>Black</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                      | 8. DATE OF BIRTH<br><u>4-10-00</u> | 9. AGE (In years last birthday)<br><u>72</u>                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>                                                                                                                                                                                                                                         |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Feed Co</u>                                                                                                                                                                                                              |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>                    |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>                                                                                                                                                                                                                                                                                                          |                      | 13. FATHER'S NAME<br><u>Wade Brown</u>                                                                                                                                                                                                                           |                                    |                                                                                 |                                                           |
| 14. MOTHER'S MAIDEN NAME<br><u>Sarah Givins</u>                                                                                                                                                                                                                                                                                                       |                      | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                            |                                    |                                                                                 |                                                           |
| 16. SOCIAL SECURITY NO.<br><u>217-54-4696</u>                                                                                                                                                                                                                                                                                                         |                      | 17. INFORMANT<br><u>Mrs Minnie Moore</u> ADDRESS <u>1935 W. Baltimore St</u>                                                                                                                                                                                     |                                    |                                                                                 |                                                           |
| 18. <u>154.1</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Carcinoma of breast with metastases to liver</u>                                                                             |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>with metastases to liver</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                                     |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr</u>                     |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>_____                                                                                                                                                                                                       |                      |                                                                                                                                                                                                                                                                  |                                    |                                                                                 |                                                           |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                    |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____                                                                                                                                                                                                        |                                    | 20A. AUTOPSY? (Yes or No) _____                                                 |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>_____                                                                                                                                                                                                                                                                         |                      | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                          |                                    |                                                                                 |                                                           |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                                                                                                                                                               |                      | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                      |                                    |                                                                                 |                                                           |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                             |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                        |                                    | 21F. HOW DID INJURY OCCUR?<br>_____                                             |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12-September 1972</u> to <u>12 September 1972</u> that (I) (we) last saw the deceased alive on <u>12 September 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |                                                                                                                                                                                                                                                                  |                                    |                                                                                 |                                                           |
| 23A. SIGNATURE<br><u>Jing Udumpanich</u>                                                                                                                                                                                                                                                                                                              |                      | DEGREE _____                                                                                                                                                                                                                                                     |                                    | 23B. DATE SIGNED<br><u>12 September 1972</u>                                    |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><u>JING UDUMPANICH, M.D.</u>                                                                                                                                                                                                                                                                                          |                      | DEGREE _____                                                                                                                                                                                                                                                     |                                    | 23D. ADDRESS<br><u>BON SECOURS HOSPITAL</u>                                     |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                             |                      | 24B. DATE<br><u>Sept 13, 1972</u>                                                                                                                                                                                                                                |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Mem PK</u>                     |                                                           |
| 24D. LOCATION<br><u>Arbutus</u>                                                                                                                                                                                                                                                                                                                       |                      | (City, town, or county)<br><u>Md</u>                                                                                                                                                                                                                             |                                    | (State)<br><u>Md</u>                                                            |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 14 1972</u>                                                                                                                                                                                                                                                                                                 |                      | 25B. NAME OF REGISTRAR<br><u>Joseph A. Russ</u>                                                                                                                                                                                                                  |                                    | 25C. FUNERAL DIRECTOR<br><u>Joseph A. Russ</u> ADDRESS <u>2222 W. North Ave</u> |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

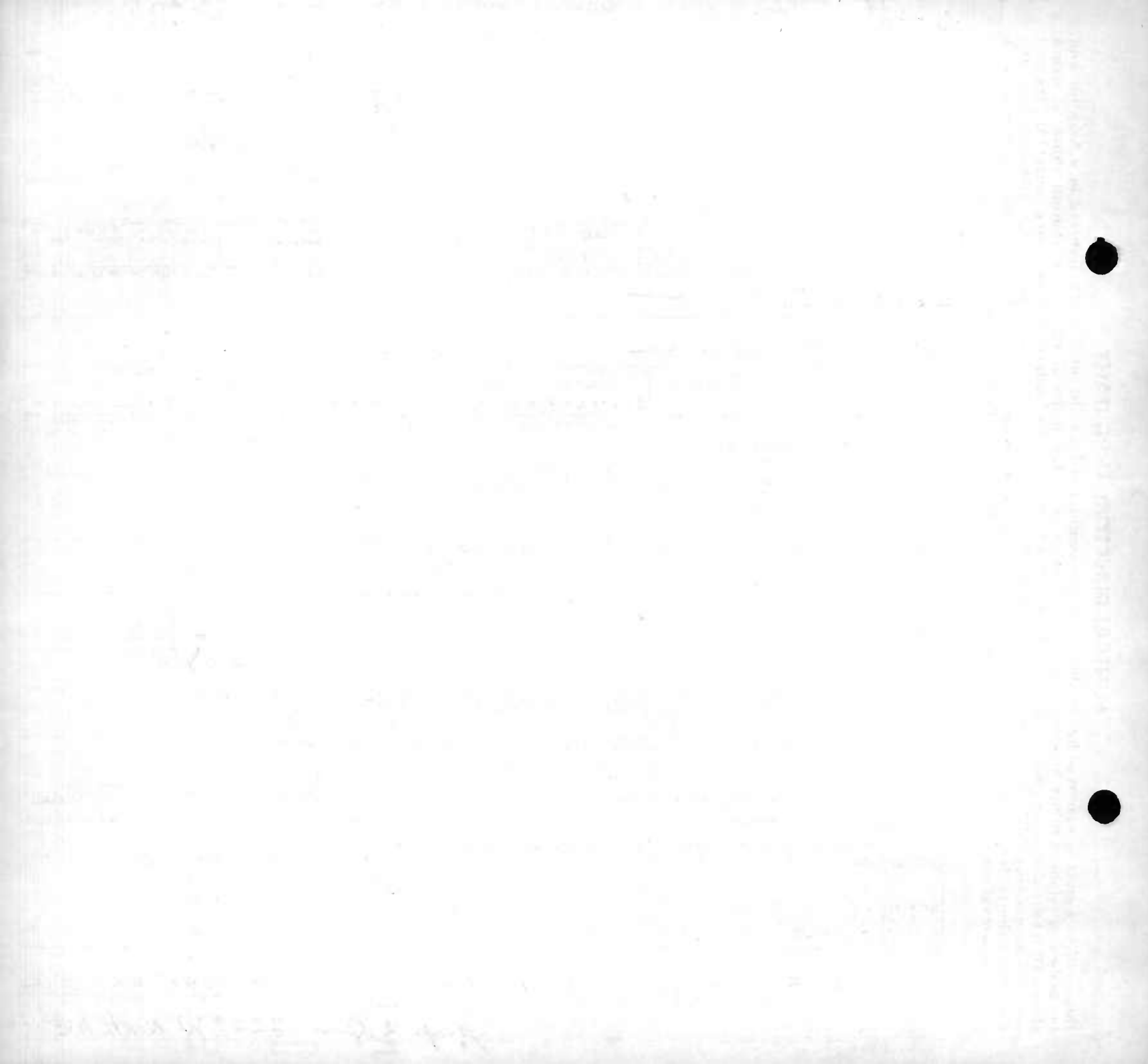
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                        |                                  |                                                                                                                                                                                                                   |  | REG. NO.<br>STATE OF MARYLAND-DEMR                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|
| T-460<br>72 08840                                                                                                                                                                                                                                                                                                                                               |                                  | 72 08840                                                                                                                                                                                                          |  |                                                                                                                                                  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                       |                                  | 1. NAME OF DECEASED<br>(Type or Print) <u>Olly A. Taylor</u>                                                                                                                                                      |  |                                                                                                                                                  |
| 2. DATE AND HOUR OF DEATH<br><u>8/24/1972</u> <u>5:35 A.M.</u>                                                                                                                                                                                                                                                                                                  |                                  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                            |  |                                                                                                                                                  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2612</u>                                                                                                                                                                                                                       |                                  | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Maryland 21224</u> |  |                                                                                                                                                  |
| 6. SEX <u>Female</u>                                                                                                                                                                                                                                                                                                                                            |                                  | 7. RACE <u>Negro</u>                                                                                                                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. DATE OF BIRTH<br><u>12-30-1884</u>                                                                                                                                                                                                                                                                                                                           |                                  | 10. AGE (in years last birthday) <u>87</u>                                                                                                                                                                        |  |                                                                                                                                                  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>                                                                                                                                                                                                                                                                                                    |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                     |  |                                                                                                                                                  |
| 13. FATHER'S NAME<br><u>Lewis</u>                                                                                                                                                                                                                                                                                                                               |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Sylvia</u>                                                                                                                                                                         |  |                                                                                                                                                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                           |                                  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                           |  | 17. INFORMANT<br><u>BCH: RECORDS</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Maryland 21224</u>                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>4122174X</u><br><u>ASCTD + Hypertension</u>                                                                                                             |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>ca 3 week</u>                                                                                                                                                  |  |                                                                                                                                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                  |                                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>20yrs, 9yrs</u><br>(B) <u>carcinomas of breast, uterus</u><br><u>9yrs, 2yrs</u><br>(C) <u>CHF, old CTD</u>                                              |  |                                                                                                                                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                          |                                  |                                                                                                                                                                                                                   |  |                                                                                                                                                  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                              |                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                  |  | 20A. AUTOPSY? (Yes or No)<br><u>no</u>                                                                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                           |                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                          |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                      |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                       |                                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                         |  | 21F. HOW DID INJURY OCCUR?                                                                                                                       |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> 19 <u>50</u> to <u>August 24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>August 24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                  |                                                                                                                                                                                                                   |  |                                                                                                                                                  |
| 23A. SIGNATURE<br><u>Hiroshi Mitsumoto</u>                                                                                                                                                                                                                                                                                                                      |                                  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                   |  | 23B. DATE SIGNED<br><u>8/24/72</u>                                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>HIROSHI MITSUMOTO</u>                                                                                                                                                                                                                                                                                                        |                                  | 23D. ADDRESS<br><u>4940 Eastern Ave. Balto, Md. 21224</u>                                                                                                                                                         |  |                                                                                                                                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                        | 24B. DATE<br><u>Sept 8, 1972</u> | 24C. NAME of CEMETERY or CREMATORY<br><u>MT Calvary Cem</u>                                                                                                                                                       |  | 24D. LOCATION (City, town, or county) (State)<br><u>Brooklyn Md</u>                                                                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 14 1972</u>                                                                                                                                                                                                                                                                                                           |                                  | 25B. NAME OF REGISTRAR<br><u>Lidney Whitson</u>                                                                                                                                                                   |  | 25C. FUNERAL DIRECTOR<br><u>Joseph J. Ben</u><br><u>2222 N. North Ave</u>                                                                        |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                             |                                               |                                                                                       |                                                                    |                                                                                               |                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------|
| W-425                                                                                                                                                                                                                                                                                                                                               |                     | 72 08841                                                                                                                                                    |                                               | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                                                                    | REG. NO. 72 08841                                                                             |                                                      |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |                                               | STATE OF MARYLAND - DISTRICT OF                                                       |                                                                    |                                                                                               |                                                      |
| 1. NAME OF DECEASED<br>(Type or Print) <u>JAMES WILSON</u>                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                             |                                               | 2. DATE AND HOUR OF DEATH<br><u>9-6-72</u> <u>12:00 P.M.</u>                          |                                                                    |                                                                                               |                                                      |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                               | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) |                                                                    |                                                                                               |                                                      |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>PROVIDENT HOSPITAL</u><br><u>LIBERTY HEIGHTS, BALTO. MD.</u>                                                                                                                                                                                                                                             |                     |                                                                                                                                                             |                                               | A. STATE<br><u>Maryland</u>                                                           |                                                                    | B. COUNTY<br><u>1601</u>                                                                      |                                                      |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |                                               | C. CITY OR TOWN<br><u>BALTIMORE</u>                                                   |                                                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                      |
| E. STREET AND NUMBER<br><u>1106 Carrollton Ave.</u>                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |                                               |                                                                                       |                                                                    |                                                                                               |                                                      |
| 5. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                                  | 6. RACE<br><u>B</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-29-08</u>            | 9. AGE (In years last birthday)<br><u>64</u>                                          | 10. Under 1 Yr. Months: Days: Hours: Min.                          | 11. Under 24 Hrs. Hours: Min.                                                                 |                                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HARDYMAN</u>                                                                                                                                                                                                                                      |                     |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>—</u> |                                                                                       | 11. BIRTHPLACE (State or foreign country)<br><u>BALTIMORE, MD.</u> |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>United States</u> |
| 13. FATHER'S NAME<br><u>George R Wilson</u>                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                               | 14. MOTHER'S MAIDEN NAME<br><u>Frances Harris</u>                                     |                                                                    |                                                                                               |                                                      |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |                                               | 16. SOCIAL SECURITY NO.<br><u>216-12-3906</u>                                         |                                                                    | 17. INFORMANT<br><u>Ruby Harris</u> ADDRESS<br><u>2013 McKean Ave</u>                         |                                                      |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>412.3 I</u><br><u>Arteriosclerotic Heart Disease</u>                                                                                       |                     |                                                                                                                                                             |                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                                                                    |                                                                                               |                                                      |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Uremia 20 to</u><br><u>Chronic Obstructive Pulmonary (COPD)</u>                                                                                                                                                |                     |                                                                                                                                                             |                                               |                                                                                       |                                                                    |                                                                                               |                                                      |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                               |                                                                                       |                                                                    |                                                                                               |                                                      |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                               | 20A. AUTOPSY? (Yes or No)                                                             |                                                                    | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                                                      |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                               |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                                                    |                                                                                               |                                                      |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                           |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                               | 21F. HOW DID INJURY OCCUR?                                                            |                                                                    |                                                                                               |                                                      |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-29</u> 19 <u>72</u> to <u>9-6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                             |                                               |                                                                                       |                                                                    |                                                                                               |                                                      |
| 23A. SIGNATURE<br><u>Gonzalo F. Guacena Jr.</u>                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                             |                                               | 23B. DATE SIGNED<br><u>9/6/72</u>                                                     |                                                                    |                                                                                               |                                                      |
| 23C. PHYSICIAN'S NAME (Type)<br><u>GONZALO F. GUACENA JR. M.D.</u>                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |                                               | 23D. ADDRESS<br><u>Provident Hospital, Balto. Md.</u>                                 |                                                                    |                                                                                               |                                                      |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                            |                     | 24B. DATE<br><u>B 9/11/72</u>                                                                                                                               |                                               | 24C. NAME OF CEMETERY OR CREMATORY<br><u>md nat ce</u>                                |                                                                    | 24D. LOCATION (City, town, or county) (State)<br><u>MURKIN Ave</u>                            |                                                      |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 14 1972</u>                                                                                                                                                                                                                                                                                               |                     | 25B. NAME OF REGISTRAR<br><u>Silvia Roberts</u>                                                                                                             |                                               | 25C. FUNERAL DIRECTOR<br><u>Joseph B. Rios</u>                                        |                                                                    | ADDRESS<br><u>2222 W NORTH AVE 21216</u>                                                      |                                                      |





1  
S-530 72 08842 STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 08842

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Mary C. Schmidt                                                                                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month 9 Day 12 Year 72<br>Estimated <input type="checkbox"/> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>00 2504 N. Calvert St.                                                                                                                                                                                                              |  | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 12 Year 72 Hour 5:10 p.m.                                                              |  |
| 6. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                              |  | 7. RACE<br>White                                                                                                              |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                              |  | C. CITY OR TOWN<br>Balto.                                                                                                     |  |
| 9. DATE OF BIRTH<br>2/11/1884                                                                                                                                                                                                                                                                                                                                                                                 |  | 10. AGE (In years last birthday)<br>88                                                                                        |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                        |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Homemaker                                                                                                                                                                                                                                                                                                      |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                                 |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                 |  | 17. SOCIAL SECURITY NO.                                                                                                       |  |
| 18. INFORMANT<br>Weldon T. Poole, 1226 Cathedral Drive                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br>L. J. Copersmith                                                                                  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Blunt force injuries of head                                                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                  |  |
| 20A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                              |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>HOME                              |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>2504 N. Calvert St.                                                                                                                                                                                                                                                                                                               |  | 22F. HOW DID INJURY OCCUR?<br>Subject beaten about head by unknown assailant.                                                 |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)<br>unk.                                                                                                                                                                                                                                                                                                                                                       |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>          |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                               |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Peter Lipkovic, M.D.                                                                                                                                                                                                                                                                                                                                            |  | DATE SIGNED<br>9/13/72                                                                                                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br>9/15/72                                                                                                          |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Trinity Luth. Ch. Cem.                                                                                                                                                                                                                                                                                                                                                  |  | 24D. LOCATION (City, town, or county) (State)<br>Westminster, Md.                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 14 1972                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br>H.W. Jenkins & Sons Co.                                                                             |  |
| 25C. FUNERAL DIRECTOR<br>21212                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br>4905 York Rd. Balto., Md.                                                                                          |  |

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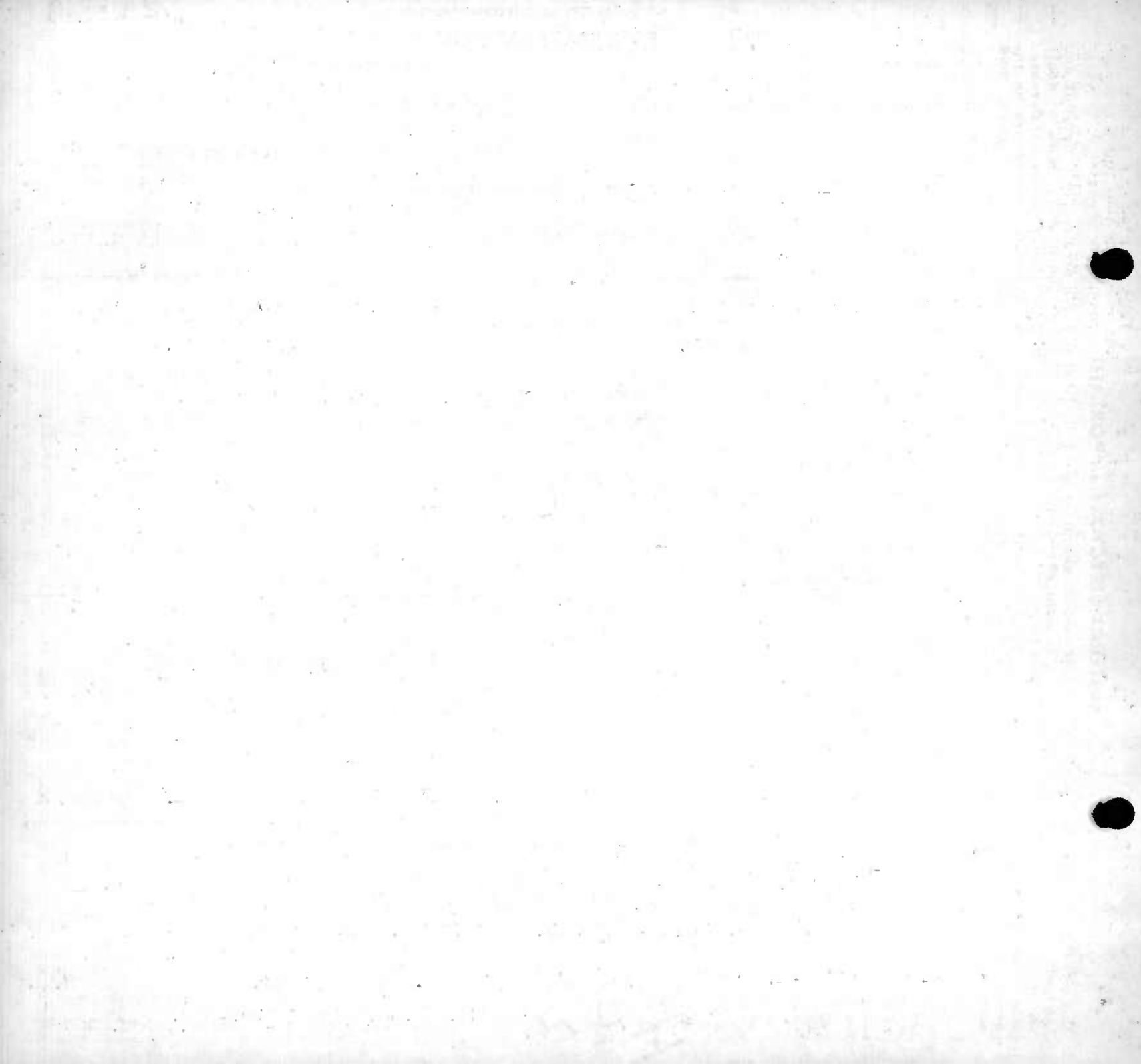
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     |                                                                                                                                                                                                                                                                  |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    | 72 08843          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------|--|
| 72 08843 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     |                                                                                                                                                                                                                                                                  |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    | REG. NO. 72 08843 |  |
| BIRTH NO. <span style="font-size: 2em;">P-415</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">Joseph J. Philbin</span>                                                             |                                                                                  |                                                                                                     |                                                                                                                                                                                                                                                                  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">Sept. 13, 1972</span> <span style="float: right;">7:30 A.M.</span> |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">00</span> 1203 Lakeside Avenue<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                               |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span><br>B. COUNTY <span style="font-size: 2em;">903</span>                                                          |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     | C. CITY OR TOWN<br><span style="font-size: 1.2em;">Baltimore</span>                                                                                                                                                                                              |                                                                                                                                 | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                                                                                                                                       |                                                                                    |                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     | E. STREET AND NUMBER<br><span style="font-size: 1.2em;">1203 Lakeside Ave. 21218</span>                                                                                                                                                                          |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 5. SEX<br><span style="font-size: 1.2em;">M</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><span style="font-size: 1.2em;">W</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">9-4-1889</span>                                 | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">83</span>                                                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Baltimore, Maryland</span>                         |                                                                                                    | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">USA</span>                                                                            |                                                                                    |                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Self Employed Real Estate</span>                                                                                                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                             |                                                                                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                   |                                                                                                                                                                                                                                                                  |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Thomas Philbin</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Mary McGowan</span>                                                                                                                                                                                  |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">Yes WWI</span>                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |                                                                                                                                                             |                                                                                  | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">215-05-8567</span>                       |                                                                                                                                                                                                                                                                  | 17. INFORMANT ADDRESS<br><span style="font-size: 1.2em;">Mr. Joseph J. Philbin, Jr. Same</span>                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 18. <span style="font-size: 2em;">412.4 I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                            |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     | CAUSE OF DEATH<br><span style="font-size: 1.5em;">Uremia</span><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.5em;">Arterio sclerotic cardiovascular disease</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                                                                                 |                                                                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.5em;">sew months</span><br><span style="font-size: 1.5em;">sew years</span> |                                                                                    |                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                           |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     |                                                                                                                                                                                                                                                                  |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">0</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                  |                                                                                                     | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                           |                                                                                                                                 | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                               |                                                                                                                                                       |                                                                                    |                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                  |                                                                                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                         |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                     | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>                                                   |                                                                                  |                                                                                                     | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                       |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9-30</span> 19 <span style="font-size: 1.2em;">61</span> to <span style="font-size: 1.2em;">9-13</span> 19 <span style="font-size: 1.2em;">72</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">9-11</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     |                                                                                                                                                                                                                                                                  |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 23A. SIGNATURE<br><span style="font-size: 1.5em;">Alfred G. Ossman Jr.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">9-14-72</span>                                                                                                                                                                                               |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Alfred G. Ossman M. D.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                     |                                                                                                                                                             |                                                                                  |                                                                                                     | 23D. ADDRESS<br><span style="font-size: 1.2em;">1101 St. Paul Street 21202</span>                                                                                                                                                                                |                                                                                                                                 |                                                                                                    |                                                                                                                                                       |                                                                                    |                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                     | 24B. DATE<br><span style="font-size: 1.2em;">9-16-72</span>                                                                                                 |                                                                                  | 24C. NAME of CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">New Cathedral Cemetery</span> |                                                                                                                                                                                                                                                                  |                                                                                                                                 | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Balto. Md.</span> |                                                                                                                                                       |                                                                                    |                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.5em;">SEP 14 1972</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                     |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.5em;">Sidney Johnston</span> |                                                                                                     |                                                                                                                                                                                                                                                                  | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.5em;">H. W. Jenkins &amp; Sons Co.</span>                                    |                                                                                                    |                                                                                                                                                       | ADDRESS<br><span style="font-size: 1.5em;">4905 York Road Balto., Md. 21212</span> |                   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                            |  | REG. NO. 72 08844                                                                                                                                           |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 72 08844                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                            |  | CERTIFICATE OF DEATH                                                                                                                                        |  |
| BIRTH NO. <u>H-200</u>                                                                                                                                                                                                                                                                                                                                             |  | STATE OF MARYLAND-DHMH                                                                                                                     |  |                                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Hamblet A. Hayes</u>                                                                                                                                                                                                                                                                                                     |  | 2. DATE AND HOUR OF DEATH<br><u>9/13/72</u> <u>835</u> a.m.                                                                                |  |                                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2714</u> |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>GOOD SAMARITAN HOSP</u><br><u>5601 LOCH RAVEN BLVD</u>                                                                                                                                                                                             |  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                        |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                              |  | 6. RACE<br><u>White</u>                                                                                                                    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><u>11-23-95</u>                                                                                                                                                                                                                                                                                                                                |  | 9. AGE (in years last birthday)<br><u>76</u>                                                                                               |  | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                                                                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman - OWNER MENT CO.</u>                                                                                                                                                                                                                                    |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>HAYES EQUIP-</u>                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Arkansas</u>                                                                                                |  |
| 13. FATHER'S NAME<br><u>John C. Hayes</u>                                                                                                                                                                                                                                                                                                                          |  | 14. MOTHER'S MAIDEN NAME<br><u>Jessie Hamlet</u>                                                                                           |  |                                                                                                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>US Navy PW I</u>                                                                                                                                                                                                                         |  | 16. SOCIAL SECURITY NO.<br><u>163-18-6206</u>                                                                                              |  | 17. INFORMANT<br><u>MRS. MARY B. HAYES</u><br><u>(Wife)</u> <u>Same as Pt.</u>                                                                              |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Ca of the lung</u>                                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>July 72</u>                                                                             |  |                                                                                                                                                             |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u>                                                                                                                                                                                                                    |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Ca of the lung</u>                                                               |  |                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                    |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                        |  |                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                    |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                        |  |                                                                                                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>                                                                                                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                          |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/12/72</u> 19 <u>72</u> to <u>9/13/72</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>9/13/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                            |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><u>I.A. Orer M.D.</u>                                                                                                                                                                                                                                                                                                                            |  | 23B. DATE SIGNED<br><u>9/13/72</u>                                                                                                         |  | 23C. PHYSICIAN'S NAME (Type)<br><u>I.A. Orer, M.D.</u>                                                                                                      |  |
| 23D. ADDRESS<br><u>Good Samaritan Hospital</u>                                                                                                                                                                                                                                                                                                                     |  | 23E. DEGREE                                                                                                                                |  |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                          |  | 24B. DATE<br><u>9/15/72</u>                                                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge</u>                                                                                                    |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Pikesville, Balto., Co., Md.</u>                                                                                                                                                                                                                                                                               |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 14 1972</u>                                                                                      |  |                                                                                                                                                             |  |
| 25B. NAME OF REGISTRAR<br><u>Henry W. Jenkins</u>                                                                                                                                                                                                                                                                                                                  |  | 25C. FUNERAL DIRECTOR<br><u>H. W. Jenkins &amp; Sons Co.</u>                                                                               |  |                                                                                                                                                             |  |
| 25D. ADDRESS<br><u>4905 York Rd. Balto., Md. 21212</u>                                                                                                                                                                                                                                                                                                             |  | 25E. DEGREE                                                                                                                                |  |                                                                                                                                                             |  |



| STATE OF MARYLAND - DEMO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 72 08845                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 72 08845                                                                                                                                                                        |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                 |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | REG. NO.                                                                                                                                                                        |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>CATHERINE HARRISON                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                                      |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>MARYLAND GENERAL HOSPITAL (DOA)                                                                                                                                                                                                                                                                                                                                                                                          |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>September 9, 1972<br>Hour Minute<br>2:20 A. M.                                                                                     |  |
| 6. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7. RACE<br>Negro                                                                                                                                                                |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                          |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                                    |  |
| 9. DATE OF BIRTH<br>Sept. 27, 1937                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |
| 10. AGE (In years lost birthday)<br>34                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | E. STREET AND NUMBER<br>731 Reservoir Street                                                                                                                                    |  |
| 11. BIRTHPLACE (State or foreign country)<br>North Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                             |  |
| 13. FATHER'S NAME<br>Matthew McCowan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House Wife                                                                        |  |
| 15. MOTHER'S MAIDEN NAME<br>Louise Alston                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                   |  |
| 17. SOCIAL SECURITY NO.<br>238-58-7999                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 18. INFORMANT ADDRESS<br>George Alston 903 N. Ducatel Street                                                                                                                    |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Fatty metamorphosis of liver<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                    |  |
| 20A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                |  |
| 21. AUTOPSY? (Yes or No)<br>yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                            |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                        |  |
| 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                          |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23.                                                                                                                                                                             |  |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                  |  |                                                                                                                                                                                 |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type)<br>Ronald N. Kornblum, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br>9/972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Removal                                                                                                                             |  |
| 24B. DATE<br>9-11-72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24C. NAME OF CEMETERY or CREMATORY<br>Red Hill Cemetery                                                                                                                         |  |
| 24D. LOCATION (City, town, or county) (State)<br>Edgecomb Co., Whitakers, North Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 14 1972                                                                                                                                  |  |
| 25B. NAME OF REGISTRAR<br>Arlington S. Phillips                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 25C. FUNERAL DIRECTOR ADDRESS<br>1727 N. Monroe Street                                                                                                                          |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                       |                             | REG. NO. <span style="float: right;">72 08846</span>                                                                                                        |                                                                             |
| BIRTH NO. <span style="float: right;">72 08846</span>                                                                                                                                                                                                                                                                                                 |                             | STATE OF MARYLAND-DHMH                                                                                                                                      |                                                                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILKES FREDERICK</b>                                                                                                                                                                                                                                                                                        |                             | 2. DATE AND HOUR OF DEATH<br><b>8:35 9/11/72</b> <span style="float: right;">a.m.</span>                                                                    |                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b>                                                                                                                                    |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL CO</b>           |                                                                             |
|                                                                                                                                                                                                                                                                                                                                                       |                             | C. CITY OR TOWN <b>GLEN BURNIE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |                                                                             |
|                                                                                                                                                                                                                                                                                                                                                       |                             | E. STREET AND NUMBER <b>EDGERLY Rd 911</b> <span style="float: right;">5200</span>                                                                          |                                                                             |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <b>W</b>            | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>10-31-21</b>                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>                                                                                                                                                                                                                                       |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>                                                                                                    | 9. AGE (in years last birthday) <b>50</b>                                   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                          |                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                  |                                                                             |
| 13. FATHER'S NAME<br><b>ANDREW FREDERICK WILKES</b>                                                                                                                                                                                                                                                                                                   |                             | 14. MOTHER'S MAIDEN NAME<br><b>IDA MAE THOMAS</b>                                                                                                           |                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 1944-1946</b>                                                                                                                                                                                                                      |                             | 16. SOCIAL SECURITY NO.<br><b>215-16-5325</b>                                                                                                               | 17. INFORMANT<br><b>HAZEL WILKES</b>                                        |
|                                                                                                                                                                                                                                                                                                                                                       |                             | ADDRESS<br><b>911 EDGERLY G. BURNIE MD.</b>                                                                                                                 |                                                                             |
| 18. <b>15333 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)<br><b>GENERAL CACHEXIA</b>                                                                                                       |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last<br><b>EXTENSIVE METASTATIC CARCINOMA</b>                                                                                                                                                                                |                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>EXTENSIVE METASTATIC CARCINOMA</b>                                                             |                                                                             |
|                                                                                                                                                                                                                                                                                                                                                       |                             | (B) <b>CARCINOMA OF THE SIGMOID</b>                                                                                                                         |                                                                             |
|                                                                                                                                                                                                                                                                                                                                                       |                             | (C)                                                                                                                                                         |                                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                |                             |                                                                                                                                                             |                                                                             |
| 19A. DATE OF OPERATION <b>9-11-72</b>                                                                                                                                                                                                                                                                                                                 |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                             |
| 20A. AUTOPSY? (Yes or No) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |                                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                        |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                             |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |                                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                             |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                             |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             |                                                                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8-28</b> 19 <b>72</b> to <b>9-12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9-11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |                                                                                                                                                             |                                                                             |
| 23A. SIGNATURE<br><b>Virma V. Torres</b> <span style="float: right;">MD DEGREE</span>                                                                                                                                                                                                                                                                 |                             | 23B. DATE SIGNED<br><b>9/11/72</b>                                                                                                                          |                                                                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Virma V. Torres</b> <span style="float: right;">MD DEGREE</span>                                                                                                                                                                                                                                                   |                             | 23D. ADDRESS<br><b>2506 W. PATAPSCO AVE APT 1-C Balt. Md.</b>                                                                                               |                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                             | 24B. DATE<br><b>9/15/72</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Glen Haven Mem.</b>                                                                                                | 24D. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, AA Md.</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                                 |                             | 25B. NAME OF REGISTRAR<br><b>Sidney White</b>                                                                                                               |                                                                             |
|                                                                                                                                                                                                                                                                                                                                                       |                             | 25C. FUNERAL DIRECTOR<br><b>Anthony General Home, Glen Burnie</b>                                                                                           |                                                                             |

2410

B-522

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08847

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>RICHARD BENGES</b>                                                                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                      |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1148 Ward St.</b>                                                                                                                                                                                                                |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>9 11 1972 7:20a M.</b>                                                     |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 7. RACE<br><b>white</b>                                                                                                         |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br><b>Balto.</b>                                                                                                |  |
| 9. DATE OF BIRTH<br><b>Oct. 30, 1933</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years last birthday)<br><b>38</b>                                                                                   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Balto, Md.</b>                                                                                                                                                                                                                                                                                                                                                |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                                                                       |  |
| 13. FATHER'S NAME<br><b>John H. Benges</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>                   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Blanche E.</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 1954-1962</b> |  |
| 17. SOCIAL SECURITY NO.<br><b>213 30 6855</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 18. INFORMANT<br><b>Lois B. Benges</b>                                                                                          |  |
| 19. CAUSE OF DEATH<br><b>asphyxia</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 20. DATE OF OPERATION<br><b>0</b>                                                                                               |  |
| 21. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>home</b>                          |  |
| 23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>1148 Ward St.</b>                                                                                                                                                                                                                                                                                                               |  | 24. HOW DID INJURY OCCUR?<br><b>Subject hung self.</b>                                                                          |  |
| 25. TIME OF INJURY (APPROX.)<br><b>9-11-72</b>                                                                                                                                                                                                                                                                                                                                                                |  | 26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                |  |
| 27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 28. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                  |  |
| 29. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                       |  | 30. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                         |  |
| 31. ACTUAL SIGNATURE<br><b>Russell S. Fisher, M.D.</b>                                                                                                                                                                                                                                                                                                                                                        |  | 32. DATE SIGNED<br><b>09-11-72</b>                                                                                              |  |
| 33. EXAMINER'S NAME (Type)<br><b>Russell S. Fisher, M.D.</b>                                                                                                                                                                                                                                                                                                                                                  |  | 34. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                            |  |
| 35. NAME OF REGISTRAR<br><b>Sidney Whitton</b>                                                                                                                                                                                                                                                                                                                                                                |  | 36. FUNERAL DIRECTOR<br><b>George J. Gonc</b>                                                                                   |  |
| 37. ADDRESS<br><b>4001 Ritchie Hgwy. Baltimore, Md. 21225</b>                                                                                                                                                                                                                                                                                                                                                 |  | 38. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Maryland</b>                                                    |  |
| 39. NAME OF CEMETERY or CREMATORY<br><b>Glen Haven Cemetery</b>                                                                                                                                                                                                                                                                                                                                               |  | 40. DATE<br><b>9/14/72</b>                                                                                                      |  |
| 41. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                      |  | 42. DATE<br><b>9/14/72</b>                                                                                                      |  |

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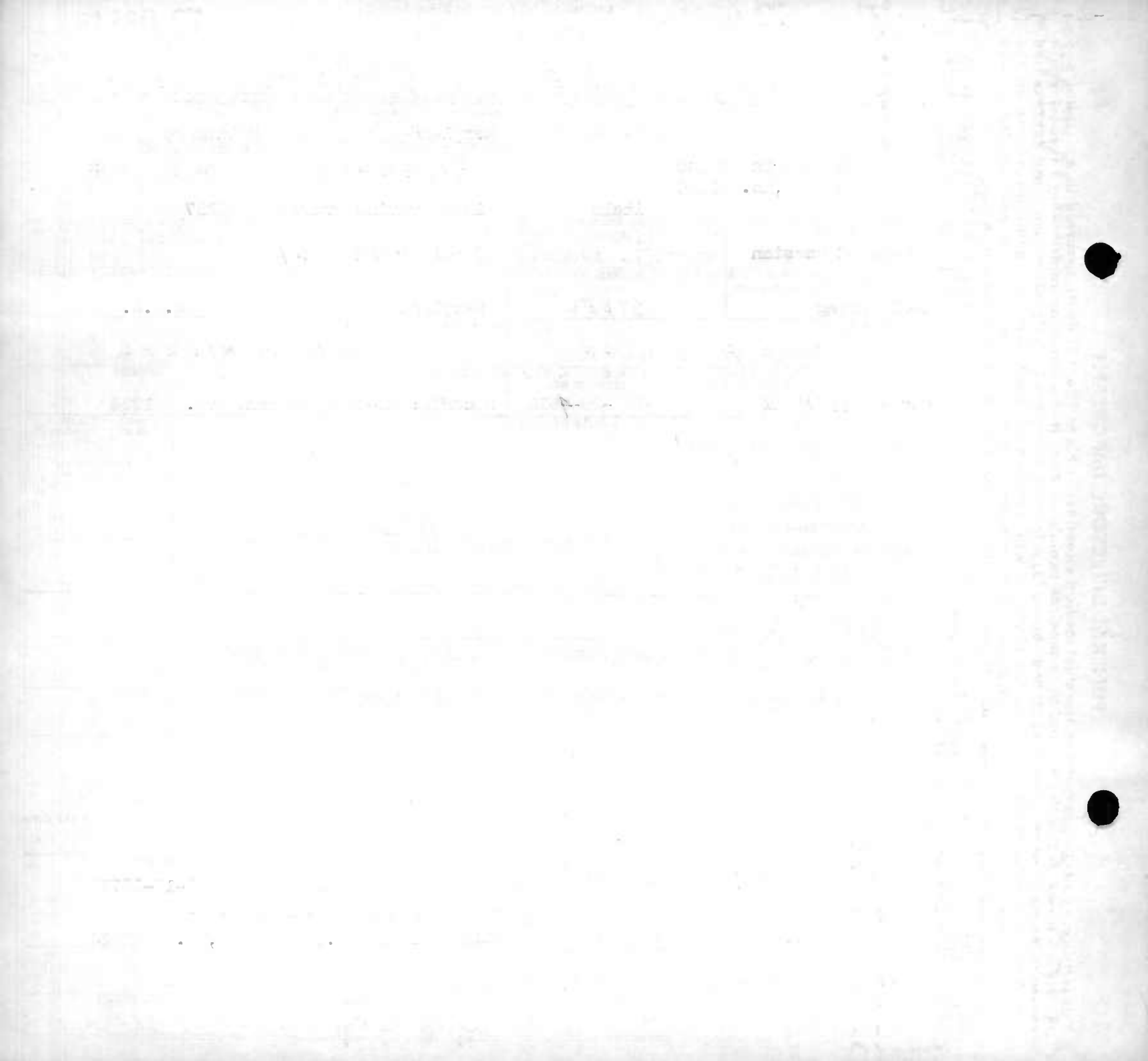
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  |                                                                            |  |                                                                                                                                              |  |                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| D-546                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 72 08848                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                           |  | CERTIFICATE OF DEATH                                                                                                                         |  | REG. NO. 72 08848                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Dimler, Roland E.</u>                                           |  |                                                                            |  | 2. DATE AND HOUR OF DEATH<br><u>9/13/72</u> <u>12:25 a.</u> M.                                                                               |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                            |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>31 Baltimore City Hospitals</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Md. 21224</u>                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                            |  | C. CITY OR TOWN<br><u>ROSEDALE</u>                                                                                                           |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 5. SEX <u>Male</u> 6. RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                          |  |                                                                                                           |  |                                                                            |  | 8. DATE OF BIRTH<br><u>JAN. 4/19/11</u>                                                                                                      |  | 9. AGE (In years last birthday) <u>61</u>                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Steel Worker</u>                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>STEEL</u>                                                                                            |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                            |  | 13. FATHER'S NAME<br><u>George A. DIMLER</u>                                                                                                 |  |                                                                                               |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Amelia H. KINZEL</u>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                            |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>YES</u> <u>WW II</u>          |  |                                                                                               |  |
| 16. SOCIAL SECURITY NO.<br><u>4938</u><br><u>216-09-4938</u>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                            |  | 17. INFORMANT<br><u>Records: BCH-4940 Eastern Ave. 21224</u>                                                                                 |  |                                                                                               |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>410.9 I</u><br><u>Acute MI</u><br><u>2 hours</u><br><u>ASCUD</u> |  |                                                                                                           |  |                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hours</u>                                                                               |  |                                                                                               |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  |                                                                            |  |                                                                                                                                              |  |                                                                                               |  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                     |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                         |  |                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                   |  | 21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location) |  |                                                                                                                                              |  |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                 |  |                                                                                                                                              |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1:30</u> <u>9/13</u> 19 <u>72</u> to <u>2:25 am</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/13/72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                    |  |                                                                                                           |  |                                                                            |  |                                                                                                                                              |  |                                                                                               |  |
| 23A. SIGNATURE<br><u>David L. Curtis M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  |                                                                            |  | 23B. DATE SIGNED<br><u>9-13-1972</u>                                                                                                         |  |                                                                                               |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>DAVID L. CURTIS M.D.</u>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                            |  | 23D. ADDRESS<br><u>Baltimore City Hospitals</u><br><u>4940 Eastern Ave., Baltimore, Md. 21224</u>                                            |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><u>9/14/72</u>                                                                               |  | 24C. NAME of CEMETERY or CREMATORY<br><u>LORRAINE CEM.</u>                 |  | 24D. LOCATION<br><u>BALTO. MD.</u>                                                                                                           |  | (City, town, or county) (State)                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 15 1972</u>                                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><u>John J. Gonnelly</u>                                                         |  | 25C. FUNERAL DIRECTOR<br><u>J. G. GONNELLY</u>                             |  | ADDRESS<br><u>300 MACE</u>                                                                                                                   |  |                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                      | 72 08849                                                                                                                                                                                                                                                                                                      |                                                          | REG. NO. 72 08849                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------|--|
| BIRTH NO. 11-532                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                      | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |                                                          |                                                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Edward J. Unitas</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                      | 2. DATE AND HOUR OF DEATH<br><i>9/12/72</i> <i>9:45</i> AM M.                                                                                                                                                                                                                                                 |                                                          |                                                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><i>Bon Secour Hospital</i><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Baltimore &amp; Payson St</i><br><i>34 Balto. Md.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             |                                      | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i><br>C. CITY OR TOWN <i>Catonsville</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <i>1008 S. HAN AVE.</i> |                                                          |                                                                   |  |
| 5. SEX <i>M</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>10/28/107</i> | 9. AGE (in years last birthday) <i>56</i>                                                                                                                                                                                                                                                                     | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |                                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Planner.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Westinghouse Electric</i>                                                                                                                                                                                                                                             |                                                          | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore Md.</i> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             |                                      | 13. FATHER'S NAME<br><i>John Unitas</i>                                                                                                                                                                                                                                                                       |                                                          |                                                                   |  |
| 14. MOTHER'S MAIDEN NAME<br><i>Agnes Svalgaris</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                      | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                      |                                                          |                                                                   |  |
| 16. SOCIAL SECURITY NO.<br><i>217-05-181</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             |                                      | 17. INFORMANT<br><i>Katheryn D. Unitas - Same</i>                                                                                                                                                                                                                                                             |                                                          |                                                                   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Obstructive Uropathy<br>Metastatic Ca of Colon<br>1 1/2 yrs<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION<br><i>2/15/72</i><br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Partial</i><br>20A. AUTOPSY? (Yes or No)<br><i>Partial</i><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>Yes</i><br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/><br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><input type="checkbox"/><br>21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><input type="checkbox"/><br>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)<br><input type="checkbox"/><br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br><input type="checkbox"/> |                  |                                                                                                                                                             |                                      |                                                                                                                                                                                                                                                                                                               |                                                          |                                                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1968</i> to <i>9/12</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>9/12/72</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                      |                                                                                                                                                                                                                                                                                                               |                                                          |                                                                   |  |
| 23A. SIGNATURE<br><i>Lester A. Spall</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                      | 23B. DATE SIGNED<br><i>9/12/72</i>                                                                                                                                                                                                                                                                            |                                                          | 23C. PHYSICIAN'S NAME (Type)<br><i>C. A. WALL JR.</i>             |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                      | 24B. DATE<br><i>9/15/72</i>                                                                                                                                                                                                                                                                                   |                                                          | 24C. NAME OF CEMETERY or CREMATORY<br><i>HOLY REDEEMER</i>        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 15 1972</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             |                                      | 25B. NAME OF REGISTRAR<br><i>Harold J. ...</i>                                                                                                                                                                                                                                                                |                                                          | 25C. FUNERAL DIRECTOR<br><i>Harold J. ...</i>                     |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08850

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                                                    |  |                                                                                               |  |                                                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>HARRY R. PHILLIPS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> <b>September 11, 1972</b>                                                         |  | Month Day Year                                                                                |  | Hour M.                                                                                                              |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>6916 McClean Blvd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 3. DATE PRONOUNCED DEAD<br><b>September 12, 1972</b>                                                                                                                               |  | Month Day Year                                                                                |  | Hour M. <b>1:10 A.M.</b>                                                                                             |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2737</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                                                                      |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                        |  | E. STREET AND NUMBER<br><b>6916 McClean Blvd.</b>                                             |  |                                                                                                                      |  |
| 9. DATE OF BIRTH<br><b>7 FEB. 1899</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 10. AGE (In years last birthday) <b>83</b>                                                                                                                                         |  | 11. BIRTHPLACE (State or foreign country)<br><b>MO.</b>                                       |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                        |  |
| 13. FATHER'S NAME<br><b>LEVIN W. PHILLIPS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OWNER/OPERATOR</b>                                                                |  | 15. MOTHER'S MAIDEN NAME<br><b>ALBERTA ROFF</b>                                               |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b> |  |
| 17. SOCIAL SECURITY NO.<br><b>215-03-8365</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 18. INFORMANT<br><b>DOROTHY P. ROWDE, 811 QUEEN DR. WESTCHESTER, PA.</b>                                                                                                           |  | 19. CAUSE OF DEATH<br><b>Bronchogenic Carcinoma</b>                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                         |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                             |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                           |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Arteriosclerotic cardiovascular disease</b> |  | 20A. DATE OF OPERATION                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                     |  |
| 21. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)      |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                             |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                          |  | 22F. HOW DID INJURY OCCUR?                                                                    |  | 23.                                                                                                                  |  |
| <p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE: <b>Marvin S. Platt, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/><br/>EXAMINER'S NAME (Type): <b>Marvin S. Platt, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br/>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED: <b>9/12/72</b></p> |                         |                                                                                                                                                                                    |  |                                                                                               |  |                                                                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 24B. DATE<br><b>15 SEPT. 72</b>                                                                                                                                                    |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>BALTIMORE CEMETERY</b>                               |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD. 21213</b>                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 25B. NAME OF REGISTRAR<br><b>Anthony [illegible]</b>                                                                                                                               |  | 25C. FUNERAL DIRECTOR<br><b>ULLRICH FUNERAL HOME, BALTO, MD. 21206</b>                        |  | ADDRESS                                                                                                              |  |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                      |                                                                                                                                                                                                                                                                                                                               |                                          |                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------|--|
| G-400<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                           |                         | 72 08851                                                                                                                                                    |                                      | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                              |                                          | REG. NO. 72 08851                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>JULIA GALLOWAY</b>                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                      | 2. DATE AND HOUR OF DEATH<br><b>9/12/72</b> <b>6 45</b> M.                                                                                                                                                                                                                                                                    |                                          |                                                                                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Caton Manor Nursing Center<br/>3330 Wilkens Ave.<br/>Baltimore, Maryland 21229</b>                                                                                                             |                         |                                                                                                                                                             |                                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b><br>C. CITY OR TOWN <b>Brooklyn</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>624 Regatta Ave.</b> |                                          |                                                                                        |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/7/1887</b> | 9. AGE (In years last birthday)<br><b>84</b>                                                                                                                                                                                                                                                                                  | If Under 1 Yr. Months: Days: Hours: Min. |                                                                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>XXXX Linen Worker</b>                                                                                                                                                                                                                                                      |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>XXXX Balto. Towel Co.</b>                                                                                           |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                  |                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                          |  |
| 13. FATHER'S NAME<br><b>George Hoffman</b>                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Barbara Kaline</b>                                                                                                                                                                                                                                                                             |                                          |                                                                                        |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>n/a</b>                                                                                                                                                                                                                                                       |                         | 16. SOCIAL SECURITY NO.<br><b>217-08-8577</b>                                                                                                               |                                      | 17. INFORMANT ADDRESS<br><b>Mr. James W. Selway, 1401 McCurley Ave. 21228</b><br><b>Mrs. Catherine Hunt Same</b>                                                                                                                                                                                                              |                                          |                                                                                        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>485 X I</b><br><b>Pneumonia</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                         |                                                                                                                                                             |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                  |                                          |                                                                                        |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                      |                                                                                                                                                                                                                                                                                                                               |                                          |                                                                                        |  |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                           |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                      | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                     |                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                      |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                      |                                          |                                                                                        |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                    |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> |                                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                    |                                          |                                                                                        |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8-14</b> 19 <b>72</b> to <b>9-12</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9-12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                      |                         |                                                                                                                                                             |                                      |                                                                                                                                                                                                                                                                                                                               |                                          |                                                                                        |  |
| 23A. SIGNATURE<br><b>DeSorption M.D.</b> DEGREE                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                      | 23B. DATE SIGNED<br><b>9-12-72</b>                                                                                                                                                                                                                                                                                            |                                          | 23C. PHYSICIAN'S NAME (Type)                                                           |  |
| 23D. ADDRESS<br>DEGREE                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                      | 23E. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                            |                                          |                                                                                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                    |                         | 24B. DATE<br><b>9-15-1972</b>                                                                                                                               |                                      | 24C. NAME OF CEMETERY or CREMATORY<br><b>Meadowridge Cemetery</b>                                                                                                                                                                                                                                                             |                                          | 24D. LOCATION (City, town, or county) (State)<br><b>Wash. Blvd. Howard County, Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                                                        |                         | 25B. NAME OF REGISTRAR<br><b>Siding Whorton</b>                                                                                                             |                                      | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                            |                                          |                                                                                        |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                 |  |                                                                                          |                                                                                       | REG. NO. 72 08852                                                                   |                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| C-626                                                                                                                                                                                                                                                                                                            |  |                                                                                          |                                                                                       | 72 08852                                                                            |                                                                                       |
| BIRTH NO.                                                                                                                                                                                                                                                                                                        |  |                                                                                          |                                                                                       | STATE OF MARYLAND - DEPT                                                            |                                                                                       |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                           |  |                                                                                          | 2. DATE AND HOUR OF DEATH                                                             |                                                                                     |                                                                                       |
| Marie E. Crigger                                                                                                                                                                                                                                                                                                 |  |                                                                                          | Sept. 12, 1972                                                                        |                                                                                     |                                                                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                           |  |                                                                                          | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                                                                                     |                                                                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                        |  |                                                                                          | A. STATE B. COUNTY                                                                    |                                                                                     |                                                                                       |
| St. Agnes Hospital<br>Caton & Wilkens Ave.                                                                                                                                                                                                                                                                       |  |                                                                                          | Maryland Balto.                                                                       |                                                                                     |                                                                                       |
| 5. SEX                                                                                                                                                                                                                                                                                                           |  |                                                                                          | 6. RACE                                                                               |                                                                                     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |
| F                                                                                                                                                                                                                                                                                                                |  |                                                                                          | White                                                                                 |                                                                                     | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                      |  |                                                                                          | 10B. KIND OF BUSINESS OR INDUSTRY                                                     |                                                                                     | 11. BIRTHPLACE (State or foreign country)                                             |
| Packer                                                                                                                                                                                                                                                                                                           |  |                                                                                          | Seafood Ind.                                                                          |                                                                                     | Maryland                                                                              |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                |  |                                                                                          | 14. MOTHER'S MAIDEN NAME                                                              |                                                                                     |                                                                                       |
| John H. Grady                                                                                                                                                                                                                                                                                                    |  |                                                                                          | Marie Stevens                                                                         |                                                                                     |                                                                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                         |  |                                                                                          | 16. SOCIAL SECURITY NO.                                                               |                                                                                     | 17. INFORMANT ADDRESS                                                                 |
| No                                                                                                                                                                                                                                                                                                               |  |                                                                                          | 212-07-0293                                                                           |                                                                                     | Robert P. Crigger 2005 Hammonds Ferry Rd.                                             |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                               |  |                                                                                          |                                                                                       |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)                                                                                                             |  |                                                                                          |                                                                                       |                                                                                     | instantly                                                                             |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                              |  |                                                                                          |                                                                                       |                                                                                     |                                                                                       |
| Acute M.I.                                                                                                                                                                                                                                                                                                       |  |                                                                                          |                                                                                       |                                                                                     |                                                                                       |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                   |  |                                                                                          |                                                                                       |                                                                                     | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |
|                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |                                                                                       |                                                                                     | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                           |  |                                                                                          |                                                                                       |                                                                                     |                                                                                       |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                                                                                       | 20A. AUTOPSY? (Yes or No)                                                           |                                                                                       |
|                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |                                                                                       |                                                                                     |                                                                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                            |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                                                                                       |
|                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |                                                                                       |                                                                                     |                                                                                       |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED                                                                     |                                                                                       | 21F. HOW DID INJURY OCCUR?                                                          |                                                                                       |
|                                                                                                                                                                                                                                                                                                                  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                                                                                       |                                                                                     |                                                                                       |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 1950 to _____ 1972, that (I) (we) lost saw the deceased olive on _____ 9/9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |                                                                                       |                                                                                     |                                                                                       |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                   |  |                                                                                          |                                                                                       | 23B. DATE SIGNED                                                                    |                                                                                       |
| John C. Pound                                                                                                                                                                                                                                                                                                    |  |                                                                                          |                                                                                       | 9/12/72                                                                             |                                                                                       |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                     |  |                                                                                          |                                                                                       | 23D. ADDRESS                                                                        |                                                                                       |
| John C. Pound                                                                                                                                                                                                                                                                                                    |  |                                                                                          |                                                                                       | 3325 Frederick Road. Baltimore, Md. 21229                                           |                                                                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                         |  | 24B. DATE                                                                                |                                                                                       | 24C. NAME OF CEMETERY or CREMATORY                                                  |                                                                                       |
| Burial                                                                                                                                                                                                                                                                                                           |  | 9-15-72                                                                                  |                                                                                       | Loudon Park Cemetery                                                                |                                                                                       |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                  |  | 25B. NAME OF REGISTRAR                                                                   |                                                                                       | 25C. FUNERAL DIRECTOR ADDRESS                                                       |                                                                                       |
| SEP 15 1972                                                                                                                                                                                                                                                                                                      |  | Howard H. Hubbard                                                                        |                                                                                       | Howard H. Hubbard Funeral Home, Inc.<br>4107 Wilkens Ave. Baltimore, Maryland 21229 |                                                                                       |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                                                                                                                                                                                               |                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>0-520</span> <span>72 08853</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>                                                                                                                 |                      | <div style="display: flex; justify-content: space-between;"> <span>REG. NO. 72 08853</span> <span>STATE OF MARYLAND-DHMH</span> </div>                                                                                                                                                                                        |                                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <b>IRMA G. OWEN</b>                                                                                                                                                                                                                                                                           |                      | 2. DATE AND HOUR OF DEATH<br><b>9/12/72 4:10 P.M.</b>                                                                                                                                                                                                                                                                         |                                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>43 SOUTH BALTO. GEN. HOSPITAL</b>                                                                                                                      |                      | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2544</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>819 Clintwood Ct.</b> |                                                 |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                      | 6. RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                                                                                   | 8. DATE OF BIRTH <b>10-20-19</b>                |
| 9. AGE (In years last birthday) <b>52</b>                                                                                                                                                                                                                                                                                            |                      | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.<br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>                                                                                                                                                                                                                        |                                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>                                                                                                                                                                                                                         |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>Lowery Glass Factory</b>                                                                                                                                                                                                                                                                 |                                                 |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                                                                                                                                                                                                                                                                            |                      | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>                                                                                                                                                                                                                                                                                     |                                                 |
| 13. FATHER'S NAME <b>ROBERT L. GATTON</b>                                                                                                                                                                                                                                                                                            |                      | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH GARHARD (dec)</b>                                                                                                                                                                                                                                                                       |                                                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>                                                                                                                                                                                                                   |                      | 16. SOCIAL SECURITY NO. <b>212-12-1185</b>                                                                                                                                                                                                                                                                                    |                                                 |
| 17. INFORMANT <b>GEORGE L. GATTON (BROTHER)</b>                                                                                                                                                                                                                                                                                      |                      | ADDRESS <b>SAME</b>                                                                                                                                                                                                                                                                                                           |                                                 |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                  |                                                 |
| 1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hepatic Insufficiency</b> <b>several weeks</b><br>(B) <b>Chronic Fatty Infiltration</b> <b>several months</b><br>(C) <b>possible alcoholic cirrhosis</b><br><b>Etiology uncertain</b>                                                                                  |                                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Malabsorption</b>                                                                                                                                                                          |                      | <b>several months</b>                                                                                                                                                                                                                                                                                                         |                                                 |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                      |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                              |                                                 |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                            |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                          |                                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                       |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                      |                                                 |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                             |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                               |                                                 |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                               |                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                    |                                                 |
| 22. I certify that (I) (this hospital) attended the deceased from <b>June 1969</b> to <b>Sept 12 1972</b> , that (I) (we) last saw the deceased alive on <b>9-12 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                      |                                                                                                                                                                                                                                                                                                                               |                                                 |
| 23A. SIGNATURE <b>Colvin C. Carter, M.D.</b>                                                                                                                                                                                                                                                                                         |                      | 23B. DATE SIGNED <b>9-12-72</b>                                                                                                                                                                                                                                                                                               |                                                 |
| 23C. PHYSICIAN'S NAME (Type) <b>Colvin C. Carter, M.D.</b>                                                                                                                                                                                                                                                                           |                      | 23D. ADDRESS <b>South Balto. Gen. Hosp.</b>                                                                                                                                                                                                                                                                                   |                                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                             | 24B. DATE            | 24C. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                            | 24D. LOCATION (City, town, or county) (State)   |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                                        | <b>Sept 16, 1972</b> | <b>Cedar Hill Cemetery</b>                                                                                                                                                                                                                                                                                                    | <b>Balto. Md</b>                                |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                   |                      | 25B. NAME OF REGISTRAR <b>Adrienne...</b>                                                                                                                                                                                                                                                                                     | 25C. FUNERAL DIRECTOR <b>Helen Federal Home</b> |
|                                                                                                                                                                                                                                                                                                                                      |                      | ADDRESS <b>4200 Pennington Ave Balto., Md.</b>                                                                                                                                                                                                                                                                                |                                                 |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                              |  |                                                                                              |  |                                                                                                          |  |                                                                                                                                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                             |  | 72 08854                                                                                     |  | CERTIFICATE OF DEATH                                                                                     |  | REG. NO. 72 08854                                                                                                                                                                                                                                                                                      |  |
| BIRTH NO. 5-530                                                                                                                              |  |                                                                                              |  | 1. NAME OF DECEASED (Type or Print) SMITH, HARRY                                                         |  |                                                                                                                                                                                                                                                                                                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                       |  |                                                                                              |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                    |  |                                                                                                                                                                                                                                                                                                        |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                    |  |                                                                                              |  | A. STATE B. COUNTY                                                                                       |  |                                                                                                                                                                                                                                                                                                        |  |
| 40 ST AGNES HOSPITAL                                                                                                                         |  |                                                                                              |  | MARYLAND HOWARD                                                                                          |  |                                                                                                                                                                                                                                                                                                        |  |
| 5. SEX MALE                                                                                                                                  |  |                                                                                              |  | 6. RACE CAUCASIAN                                                                                        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                  |  |
| 8. DATE OF BIRTH 10/15/17                                                                                                                    |  |                                                                                              |  | 9. AGE (In years last birthday) 54                                                                       |  | 10. BIRTHPLACE (State or foreign country) WEST VIRGINIA                                                                                                                                                                                                                                                |  |
| 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA                                                                                      |  |                                                                                              |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                      |  | 13. FATHER'S NAME LOUIS SMITH                                                                                                                                                                                                                                                                          |  |
| 14. MOTHER'S MAIDEN NAME SARAH JANE KURKENDOLL                                                                                               |  |                                                                                              |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO. 232-26-2322                                                                                                                                                                                                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                     |  |                                                                                              |  | 16. SOCIAL SECURITY NO. 232-26-2322                                                                      |  | 17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS CATON AND WILKENS AVENUES BALTO MD 21229                                                                                                                                                                                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                           |  |                                                                                              |  | 19. CAUSE OF DEATH                                                                                       |  | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                       |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |  |                                                                                              |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                      |  | Metastatic G prostate yrs.                                                                                                                                                                                                                                                                             |  |
| ANTECEDENT CAUSES                                                                                                                            |  |                                                                                              |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                      |  | Carcinoma of Prostate yrs.                                                                                                                                                                                                                                                                             |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |  |                                                                                              |  | (C) ASCVD                                                                                                |  | yrs.                                                                                                                                                                                                                                                                                                   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).          |  |                                                                                              |  |                                                                                                          |  |                                                                                                                                                                                                                                                                                                        |  |
| 19A. DATE OF OPERATION 1/8/72                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TUR prostate                                |  | 20A. AUTOPSY? (Yes or No) NO                                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                        |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                              |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                               |  | 22. I certify that XX (this hospital) attended the deceased from 08/28 19 72 to 09/09 19 72, that XX (we) last saw the deceased alive on 09/09 19 72 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) (XXXX) view the body after death. |  |
| 23A. SIGNATURE GR. Chaney M.D.                                                                                                               |  | 23B. DATE SIGNED 9/9/72                                                                      |  | 23C. PHYSICIAN'S NAME (Type) DEGREE                                                                      |  | 23D. ADDRESS ST AGNES HOSPITAL                                                                                                                                                                                                                                                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                     |  | 24B. DATE 9/12/72                                                                            |  | 24C. NAME OF CEMETERY or CREMATORY Christ Episcopal Church                                               |  | 24D. LOCATION (City, town, or county) (State) Guilford Md                                                                                                                                                                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 15 1972                                                                                                  |  | 25B. NAME OF REGISTRAR Andrew H. ...                                                         |  | 25C. FUNERAL DIRECTOR ...                                                                                |  | 25D. ADDRESS ...                                                                                                                                                                                                                                                                                       |  |

8:30 P.

SEPTEMBER 2, 1971

SMITH, JAMES

MARYLAND

BY ADAMS HOSPITAL

2000 MILLERS ROAD, JETON

101512

NOTE: 2-10-71

U.S.A.

WEST VIRGINIA

CONSTRUCTION

CAPITOL

JAMES JANE KIRKWOOD

LOUIS SMITH

ST AGNES HOSPITAL, RECORDER CATION AND  
WALKING AVENUE, 5110 N. 1111

W.C. WOODWARD

ST AGNES HOSPITAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                   |                                                                                               |                                                  |                                                                      |                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------|------------------------|
| D-120                                                                                                                                                                                                                                                                                                 |                      | 72 08855                                                                                                                                                    |                                   | BALTIMORE CITY HEALTH DEPARTMENT                                                              |                                                  | 72 08855                                                             |                        |
| BIRTH NO.                                                                                                                                                                                                                                                                                             |                      | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                                   | 2. DATE AND HOUR OF DEATH                                                                     |                                                  | REG. NO.                                                             |                        |
|                                                                                                                                                                                                                                                                                                       |                      | MARGARET E DAVIS                                                                                                                                            |                                   | 9/11/72 - 9:02                                                                                |                                                  | A M.                                                                 |                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                |                      |                                                                                                                                                             |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)         |                                                  |                                                                      |                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Md. 21224                                                                                                                                                                                       |                      |                                                                                                                                                             |                                   | A. STATE<br>Maryland<br>B. COUNTY<br>Baltimore                                                |                                                  |                                                                      |                        |
| C. CITY OR TOWN<br>COLGATE                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |                                   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                  |                                                                      |                        |
| E. STREET AND NUMBER<br>7606 Riddle Avenue 21224                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                   |                                                                                               |                                                  |                                                                      |                        |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                      | 6. RACE<br>Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>9/2/95        | 9. AGE (In years lost birthday)<br>77                                                         | 10. Under 1 Yr. Months                           | 11. Under 24 Hrs. Days                                               | 12. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>H. W.                                                                                                                                                                                                  |                      |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY |                                                                                               | 11. BIRTHPLACE (State or foreign country)<br>MD. |                                                                      |                        |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             |                                   |                                                                                               |                                                  |                                                                      |                        |
| 13. FATHER'S NAME<br>FREDERICK DOCHTERMAN                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |                                   | 14. MOTHER'S MAIDEN NAME<br>UNK                                                               |                                                  |                                                                      |                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                        |                      | 16. SOCIAL SECURITY NO.<br>220-01-6608                                                                                                                      |                                   | 17. INFORMANT<br>Records: BCH-4940 Eastern Ave.                                               |                                                  | ADDRESS<br>21224                                                     |                        |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>CARDIAC ARREST                                                                |                      |                                                                                                                                                             |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>15 MINUTES.                                   |                                                  |                                                                      |                        |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>RESPIRATORY INSUFFICIENCY                                                                                                                                           |                      |                                                                                                                                                             |                                   | 10 DAYS                                                                                       |                                                  |                                                                      |                        |
| (C) ADDEND CARCINOMA OF GALLBLADDER.                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |                                   | 4+ MONTHS                                                                                     |                                                  |                                                                      |                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                |                      |                                                                                                                                                             |                                   |                                                                                               |                                                  |                                                                      |                        |
| 19A. DATE OF OPERATION<br>9/11/72                                                                                                                                                                                                                                                                     |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>OBSTRUCTIVE JAUNDICE                                                                                    |                                   | 20A. AUTOPSY? (Yes or No)<br>NO                                                               |                                                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                 |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)                                                                   |                                   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |                                                  |                                                                      |                        |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                          |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                   | 21F. HOW DID INJURY OCCUR?                                                                    |                                                  |                                                                      |                        |
| 22. I certify that (I) (this hospital) attended the deceased from 8/19 1972 to 9/11 1972 that (I) (we) lost saw the deceased alive on 9/11/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |                      |                                                                                                                                                             |                                   |                                                                                               |                                                  |                                                                      |                        |
| 23A. SIGNATURE<br>Alexander Guba                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                   | 23B. DATE SIGNED<br>9/11/72                                                                   |                                                  | 23C. PHYSICIAN'S NAME (Type)<br>Alexander Guba                       |                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                    |                      | 24B. DATE<br>9/15/72                                                                                                                                        |                                   | 24C. NAME OF CEMETERY or CREMATORY<br>ZION LUTHERAN                                           |                                                  | 24D. LOCATION (City, town, or county) (State)<br>BALTO. MD.          |                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 15 1972                                                                                                                                                                                                                                                        |                      | 25B. NAME OF REGISTRAR<br>J. G. CANNELLY                                                                                                                    |                                   | 25C. FUNERAL DIRECTOR<br>J. G. CANNELLY                                                       |                                                  | ADDRESS<br>300 MACE                                                  |                        |

BURIAL 4/2/25 ZION LUTHERAN BALTO MD

No

FREDERICK

DOCHTERMAN

NK

MD

H.W.

UZA

4/2/25

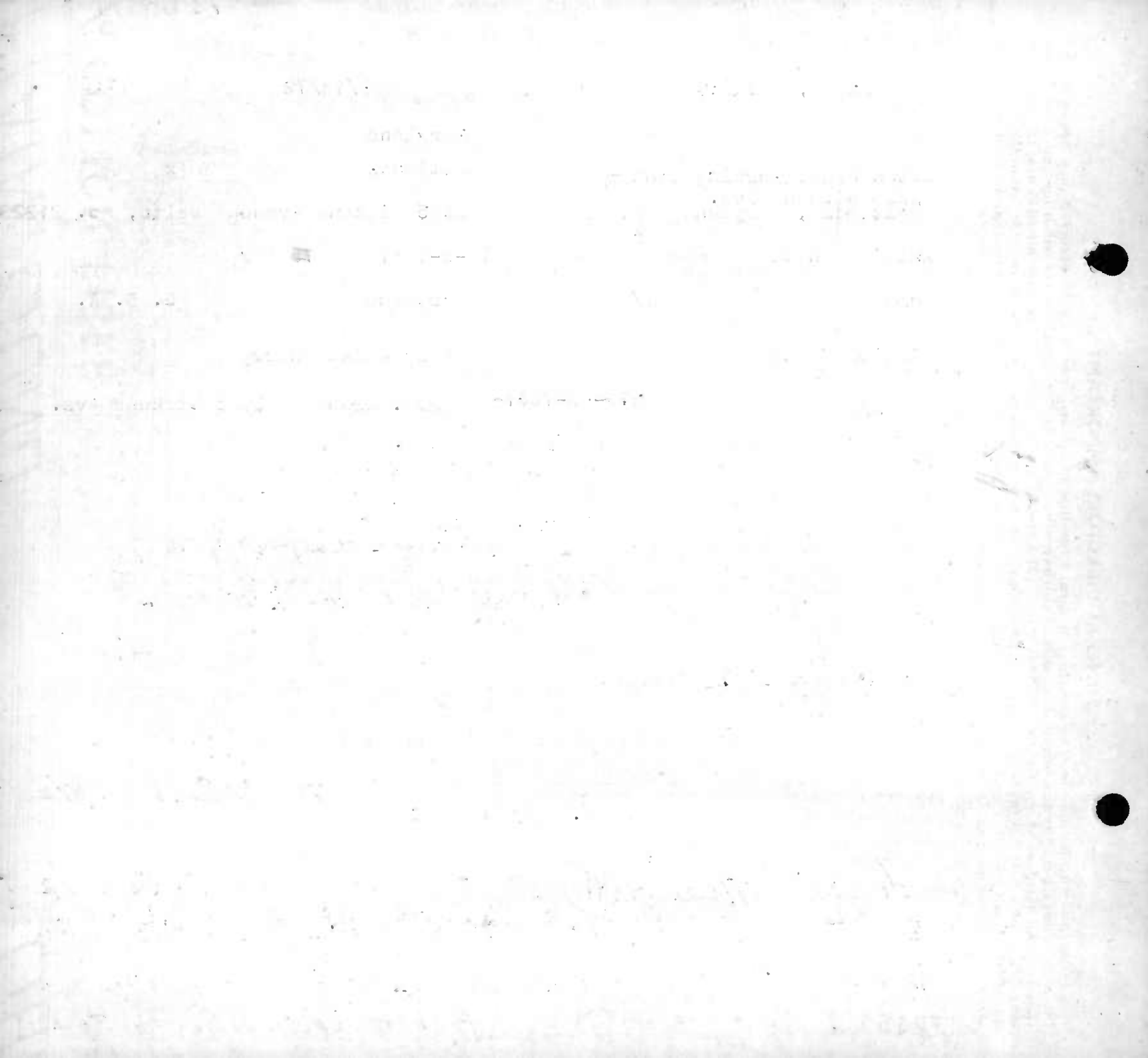
25

CORCATE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                            |         |                                                                                         |                  |                                                                                       |                                                                                            |                                                                      |                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------|
| K-620                                                                                                                                                                                                                                                                                                      |         | 72 08856                                                                                |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                                                                                            | 72 08856                                                             |                              |
| BIRTH NO.                                                                                                                                                                                                                                                                                                  |         |                                                                                         |                  | REG. NO.                                                                              |                                                                                            |                                                                      |                              |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                     |         |                                                                                         |                  | 2. DATE AND HOUR OF DEATH                                                             |                                                                                            |                                                                      |                              |
| Kraus, William                                                                                                                                                                                                                                                                                             |         |                                                                                         |                  | 9/13/72 11:50 A.M.                                                                    |                                                                                            |                                                                      |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                     |         |                                                                                         |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) |                                                                                            |                                                                      |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                               |         |                                                                                         |                  | A. STATE B. COUNTY                                                                    |                                                                                            |                                                                      |                              |
| Caton Manor Nursing Center<br>3330 Wilkens Ave.<br>Baltimore, Maryland 21229                                                                                                                                                                                                                               |         |                                                                                         |                  | Maryland                                                                              |                                                                                            |                                                                      |                              |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                         |                  | C. CITY OR TOWN                                                                       |                                                                                            | D. INSIDE CITY LIMITS?                                               |                              |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                         |                  | Baltimore                                                                             |                                                                                            | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                              |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                         |                  | E. STREET AND NUMBER                                                                  |                                                                                            |                                                                      |                              |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                         |                  | 2645 Wilkens Avenue Balto, Md. 21223                                                  |                                                                                            |                                                                      |                              |
| 5. SEX                                                                                                                                                                                                                                                                                                     | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                                       | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country)                            | 12. CITIZEN OF WHAT COUNTRY? |
| Male                                                                                                                                                                                                                                                                                                       | White   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      | 10-5-1897        | 14                                                                                    | n/a                                                                                        | Maryland                                                             | U. S. A.                     |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                          |         |                                                                                         |                  | 14. MOTHER'S MAIDEN NAME                                                              |                                                                                            |                                                                      |                              |
| William Kraus                                                                                                                                                                                                                                                                                              |         |                                                                                         |                  | Mary Ellen Sherry                                                                     |                                                                                            |                                                                      |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                   |         |                                                                                         |                  | 16. SOCIAL SECURITY NO.                                                               |                                                                                            | 17. INFORMANT ADDRESS                                                |                              |
| n/a                                                                                                                                                                                                                                                                                                        |         |                                                                                         |                  | 213-05-7687-A                                                                         |                                                                                            | Mrs. Kraus 2645 Wilkens Ave.                                         |                              |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                          |         |                                                                                         |                  | CAUSE OF DEATH                                                                        |                                                                                            |                                                                      |                              |
| II                                                                                                                                                                                                                                                                                                         |         |                                                                                         |                  | Arteriosclerotic Degenerative Cardiovascular disease                                  |                                                                                            |                                                                      |                              |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                          |         |                                                                                         |                  | Marked Peripheral Vascular Insufficiency                                              |                                                                                            |                                                                      |                              |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                  |         |                                                                                         |                  | (B) Circulatory Collapse + death                                                      |                                                                                            |                                                                      |                              |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                         |                  | (C) Amputation Gangrenous left foot & leg and decubitus ulcers buttocks               |                                                                                            |                                                                      |                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                           |         |                                                                                         |                  | none                                                                                  |                                                                                            |                                                                      |                              |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                     |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                        |                  | 20A. AUTOPSY? (Yes or No)                                                             |                                                                                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                              |
| 26, 21 July 72                                                                                                                                                                                                                                                                                             |         | Gangrene                                                                                |                  | No.                                                                                   |                                                                                            |                                                                      |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                      |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |                  | 21C. WHERE DID INJURY OCCUR?                                                          |                                                                                            | (If in Baltimore City, give exact location)                          |                              |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                         |                  |                                                                                       |                                                                                            |                                                                      |                              |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                              |         | 21E. INJURY OCCURRED                                                                    |                  | 21F. HOW DID INJURY OCCUR?                                                            |                                                                                            |                                                                      |                              |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |                  |                                                                                       |                                                                                            |                                                                      |                              |
| 22. I certify that (I) (this hospital) attended the deceased from 1971 to 13 Sept 1972, that (I) (we) last saw the deceased alive on 12 Sept 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                         |                  |                                                                                       |                                                                                            |                                                                      |                              |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                             |         |                                                                                         |                  | 23B. DATE SIGNED                                                                      |                                                                                            |                                                                      |                              |
| Joseph E. Muse Jr. M.D.                                                                                                                                                                                                                                                                                    |         |                                                                                         |                  | 13 Sept. '72                                                                          |                                                                                            |                                                                      |                              |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                               |         |                                                                                         |                  | 23D. ADDRESS                                                                          |                                                                                            |                                                                      |                              |
|                                                                                                                                                                                                                                                                                                            |         |                                                                                         |                  | 901 Pine Hts Ave. Balto. 29, Md                                                       |                                                                                            |                                                                      |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                   |         | 24B. DATE                                                                               |                  | 24C. NAME OF CEMETERY or CREMATORY                                                    |                                                                                            | 24D. LOCATION (City, town, or county) (State)                        |                              |
| Burial                                                                                                                                                                                                                                                                                                     |         | 9/14/72                                                                                 |                  | Meadowridge Cemetery                                                                  |                                                                                            | Dorsey Maryland                                                      |                              |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                            |         | 25B. NAME OF REGISTRAR                                                                  |                  | 25C. FUNERAL DIRECTOR                                                                 |                                                                                            | ADDRESS                                                              |                              |
| SEP 15 1972                                                                                                                                                                                                                                                                                                |         | Anthony Houston                                                                         |                  | Ambrosio, Inc. 1328 S. 14th St. Rd                                                    |                                                                                            |                                                                      |                              |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| A-260                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 72 08857                                                                                                                                                    |                                                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                           |                                                                                            | 72 08857                                                                                      |  |
| <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                  | REQ. NO. <u>72 08857</u>                                                                                                                   |                                                                                            |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Asher, Lois ANN</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                  | 2. DATE AND HOUR OF DEATH<br><u>9/11/72</u> <u>125</u> P.M.                                                                                |                                                                                            |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Sinai Hospital of Baltimore</u>                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2755</u> |                                                                                            |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                        |                                                                                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                  | E. STREET AND NUMBER<br><u>1607 Sulgrave Ave.</u>                                                                                          |                                                                                            |                                                                                               |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-07-49</u>               | 9. AGE (In years last birthday)<br><u>23</u>                                                                                               | If Under 1 Yr. Months Days                                                                 | If Under 24 Hrs. Hours Min.                                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                |                                                                                                                                            | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore city</u>                         |                                                                                               |  |
| 13. FATHER'S NAME<br><u>William Edwin Grueninger</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Elsie M. Kane</u> |                                                                                                                                            | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                              |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><u>215 540928</u>     |                                                                                                                                            | 17. INFORMANT <u>Edwin Grueninger</u> ADDRESS<br><u>Elsie M. Kane 5709 Rush Ave. 21215</u> |                                                                                               |  |
| 18. <u>205.11</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         |                                                                                                                                                             |                                                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Chronic Granulocytic Leukemia</u>                                                |                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u>                                |  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                  | 20A. AUTOPSY? (Yes or No)                                                                                                                  |                                                                                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                   |                                                                                            |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                  | 21F. HOW DID INJURY OCCUR?                                                                                                                 |                                                                                            |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 13</u> 19 <u>72</u> to <u>Sept. 11</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Sept. 11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.                                                                                                                                               |                         |                                                                                                                                                             |                                                  |                                                                                                                                            |                                                                                            |                                                                                               |  |
| 23A. SIGNATURE<br><u>Marcel L. Chaiken M.D.</u> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>            |                                                                                            | 23B. DATE SIGNED<br><u>9/11/72</u>                                                            |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                  | 23D. ADDRESS                                                                                                                               |                                                                                            |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 24B. DATE<br><u>9/14/72</u>                                                                                                                                 |                                                  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Moreland Memorial Park</u>                                                                        |                                                                                            | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore County Maryland</u>             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 15 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 25B. NAME OF REGISTRAR<br><u>Anthony M. Gordon</u>                                                                                                          |                                                  | 25C. FUNERAL DIRECTOR<br><u>Burges Funeral Home</u> ADDRESS<br><u>3631 Falls Road</u>                                                      |                                                                                            |                                                                                               |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                  | 72 08858                                                                                                                                     |                                                            | REG. NO. 72 08858                                                       |                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------|
| BIRTH NO. B-500                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |                                                  | CERTIFICATE OF DEATH                                                                                                                         |                                                            |                                                                         |                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Janie N. Bowen</b>                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                                  | 2. DATE AND HOUR OF DEATH<br><b>September 10, 1972 12:55 A.M.</b>                                                                            |                                                            |                                                                         |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> |                                                            |                                                                         |                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>90 The Wesley Home, Inc.</b>                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                                  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |                                                            |                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |                                                  | E. STREET AND NUMBER <b>2211 West Rogers Avenue</b>                                                                                          |                                                            |                                                                         |                                           |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                    | 6. RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Nov. 3, 1880</b>             |                                                                                                                                              | 9. AGE (In years last birthday) <b>91</b>                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.               |                                           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                    |                  |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                |                                                                                                                                              | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |                                                                         | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b> |
| 13. FATHER'S NAME <b>Michael H. Sweetmon</b>                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME <b>Rebecca Williams</b> |                                                                                                                                              |                                                            |                                                                         |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                              |                  |                                                                                                                                                             | 16. SOCIAL SECURITY NO. <b>218 52 1167 J1</b>    |                                                                                                                                              | 17. INFORMANT <b>Wesley Home, Inc.</b> ADDRESS <b>Same</b> |                                                                         |                                           |
| 18. <b>412.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiac vascular disease</b>                                                                           |                  |                                                                                                                                                             |                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                 |                                                            |                                                                         |                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:            |                                                            |                                                                         |                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                                  |                                                                                                                                              |                                                            |                                                                         |                                           |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                                    |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                  | 20A. AUTOPSY? (Yes or No) <b>No</b>                                                                                                          |                                                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                     |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                     |                                                            |                                                                         |                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                          |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                  | 21F. HOW DID INJURY OCCUR?                                                                                                                   |                                                            |                                                                         |                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8 August 1972</b> to <b>10 September 1972</b> , that (I) (we) last saw the deceased alive on <b>7 September 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                                                  |                                                                                                                                              |                                                            |                                                                         |                                           |
| 23A. SIGNATURE <b>John W. Barnaby</b>                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                             |                                                  | 23B. DATE SIGNED <b>11 Sept 72</b>                                                                                                           |                                                            |                                                                         |                                           |
| 23C. PHYSICIAN'S NAME (Type) <b>Dr. John W. Barnaby</b>                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                                  | 23D. ADDRESS <b>1652 E. Belvedere Avenue</b>                                                                                                 |                                                            |                                                                         |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                             |                  | 24B. DATE <b>13 Sept 72</b>                                                                                                                                 |                                                  | 24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>                                                                                  |                                                            | 24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b> |                                           |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                                 |                  | 25B. NAME OF REGISTRAR <b>Anthony J. [Signature]</b>                                                                                                        |                                                  | 25C. FUNERAL DIRECTOR <b>Burgee Funeral Home, Balto., Md.</b>                                                                                |                                                            | ADDRESS <b>611 Water St. [Signature]</b>                                |                                           |

Wesley to Return call

2

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08859

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MELVIN HOLMES

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

September 8, 1972

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

JOHNS HOPKINS HOSPITAL

3. DATE

Month

Day

Year

Hour

P.M.

September 8, 1972

3:25 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

703

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Feb 19-1929

10. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

513 N. Chester Street

11. BIRTHPLACE (State or foreign country)

Baltimore and

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Melvin Holmes

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

City Employee

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Daisy Holmes

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give word or dates of service)

yes

17. SOCIAL  
SECURITY NO.

214-24-1184

18. INFORMANT

Lorraine V. Holmes Same

ADDRESS

19. E 966 X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Stab wounds of chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

800 Block N. Chester Street

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

9-8-72

2:40 P. M.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed during altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Marvin S. Platt, M.D.

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/9/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

9-12-72

24C. NAME OF CEMETERY or CREMATORY

MT CALVARY CEM

24D. LOCATION (City, town, or county)

ARUNDEL Co. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 15 1972

25B. NAME OF REGISTRAR

Sidney Houston

25C. FUNERAL DIRECTOR

ELOY O. WILSON

ADDRESS

1000 BRANTLEY AVE

1914-1915

1914-1915

1914-1915

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1914-1915

72 08880 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 72 08880  
 STATE OF MARYLAND-DHMH

|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                 |  |                                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                 |  | 1. NAME OF DECEASED<br>(Type or Print) <b>HERBERT L. MALONE</b>                                                                                                                 |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                                                  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                           |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>September 8, 1972</b>                                                                                                           |  | Hour<br><b>1:35 P.</b>                                                                                                                                      |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 7. RACE<br><b>Negro</b>                                                                                                                                                         |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>10-30-1943</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 10. AGE (In years last birthday)<br><b>28</b>                                                                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTO. Md.</b>                                                                                              |  |
| 12. CITIZEN OF<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 13. FATHER'S NAME<br><b>COLEY MALONE</b>                                                                                                                                        |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>LILLIE MAE WEST</b>                                                                                                                                                                                                                                                                                                                                                        |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                         |  | 17. SOCIAL SECURITY NO.                                                                                                                                     |  |
| 18. INFORMANT<br><b>COLEY MALONE</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 19. ADDRESS<br><b>2002 E. CHASE ST.</b>                                                                                                                                         |  | 20. CAUSE OF DEATH<br><b>Multiple gunshot wounds of chest</b>                                                                                               |  |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                          |  | 22. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                              |  | 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                        |  |
| 24A. DATE OF OPERATION<br><b>9-8-72</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 24B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                |  | 24C. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                     |  |
| 25A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                           |  | 25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Rear (alley?)</b>                                                                |  | 25C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Rear 913 N. Caroline Street</b>                                              |  |
| 26A. TIME (Month) (Day) (Year) (Hour)<br><b>9-8-72 1:00 P.m.</b>                                                                                                                                                                                                                                                                                                                                          |  | 26B. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                            |  | 26C. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                                 |  |                                                                                                                                                             |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>                                                                                                                                                                                                                                                                                                                             |  | Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  | DATE SIGNED<br><b>9/9/72</b>                                                                                                                                |  |
| 27A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                 |  | 27B. DATE<br><b>9-13-72</b>                                                                                                                                                     |  | 27C. NAME OF CEMETERY or CREMATORY<br><b>Mt Auburn Cem</b>                                                                                                  |  |
| 27D. LOCATION (City, town, or county) (State)<br><b>BALTO. Md.</b>                                                                                                                                                                                                                                                                                                                                        |  | 27E. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                                           |  | 27F. NAME OF REGISTRAR<br><b>Sidney W. Horton</b>                                                                                                           |  |
| 27G. FUNERAL DIRECTOR<br><b>Elroy A. Wilson</b>                                                                                                                                                                                                                                                                                                                                                           |  | 27H. ADDRESS<br><b>1000 BRANTLEY AVE</b>                                                                                                                                        |  | 27I. DATE<br><b>9/5/72</b>                                                                                                                                  |  |

10-30 1943

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                  |                                                    | 72 08861                                                                                                             |                                                                                                      | REG. NO. 72 08861                                                                             |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                  |                                                    | STATE OF MARYLAND-DEME                                                                                               |                                                                                                      |                                                                                               |                                              |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Marcellus Rose</i>                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                  |                                                    | 2. DATE AND HOUR OF DEATH<br><i>Sept 10, 1972</i>   <i>105</i> P. M.                                                 |                                                                                                      |                                                                                               |                                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                  |                                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                |                                                                                                      |                                                                                               |                                              |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Baltimore City Hospitals</i><br><i>4940 Eastern Avenue- Baltimore, Maryland</i>                                                                                                                                                              |                         |                                                                                                                                                  |                                                    | A. STATE<br><i>Maryland</i>                                                                                          |                                                                                                      | B. COUNTY<br><i>1607</i>                                                                      |                                              |
|                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  |                                                    | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                  |                                                                                                      | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
|                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  |                                                    | E. STREET AND NUMBER<br><i>1619 N. Ellmont St.</i>                                                                   |                                                                                                      |                                                                                               |                                              |
| 5. SEX<br><i>M</i>                                                                                                                                                                                                                                                                                                                                           | 6. RACE<br><i>negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>3/5/198</i>                 | 9. AGE (in years last birthday)<br><i>27</i>                                                                         | If Under 1 Yr. Months Days                                                                           |                                                                                               | If Under 24 Hrs. Hours Min.                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>retired</i>                                                                                                                                                                                                                                                |                         |                                                                                                                                                  | 10B. KIND OF BUSINESS OR INDUSTRY                  |                                                                                                                      | 11. BIRTHPLACE (State or foreign country)<br><i>South Carolina</i>                                   |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i> |
| 13. FATHER'S NAME<br><i>John Titus</i>                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                  | 14. MOTHER'S MAIDEN NAME<br><i>Alma Singletary</i> |                                                                                                                      |                                                                                                      |                                                                                               |                                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                                                        |                         |                                                                                                                                                  | 16. SOCIAL SECURITY NO.<br><i>250-20-6999</i>      |                                                                                                                      | 17. INFORMANT ADDRESS<br>BCH RECORDS: <i>4940 Eastern Avenue</i><br><i>Baltimore, Maryland 21224</i> |                                                                                               |                                              |
| 18. <i>486X1+250.9</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.    |                         |                                                                                                                                                  |                                                    | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Respiratory arrest</i>                                  |                                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 day</i>                                  |                                              |
|                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  |                                                    | (B) <i>brain stem stroke</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                                      |                                                                                                      |                                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  |                                                    | (C) <i>pneumonia, GI bleed</i>                                                                                       |                                                                                                      |                                                                                               |                                              |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                       |                         |                                                                                                                                                  |                                                    | <i>diabetes, abdominal tumor</i>                                                                                     |                                                                                                      |                                                                                               |                                              |
| 19A. DATE OF OPERATION<br><i>9</i>                                                                                                                                                                                                                                                                                                                           |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                    | 20A. AUTOPSY? (Yes or No)                                                                                            |                                                                                                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                        |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                             |                                                                                                      |                                                                                               |                                              |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                    |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                        |                                                    | 21F. HOW DID INJURY OCCUR?                                                                                           |                                                                                                      |                                                                                               |                                              |
| 22. I certify that (If this hospital) attended the deceased from <i>Sept 9</i> 19 <i>72</i> to <i>Sept 10</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>Sept 10</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                  |                                                    |                                                                                                                      |                                                                                                      |                                                                                               |                                              |
| 23A. SIGNATURE<br><i>Marilee C.S. Cole, M.D.</i>                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                  |                                                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                                                                                      | 23B. DATE SIGNED<br><i>Sept 10, 1972</i>                                                      |                                              |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Marilee Cole, M.D.</i>                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                  |                                                    | 23D. ADDRESS<br><i>Baltimore City Hospitals</i><br><i>4940 Eastern Avenue</i>                                        |                                                                                                      |                                                                                               |                                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                     |                         | 24B. DATE<br><i>9-15-72</i>                                                                                                                      |                                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Conner Memorial Park</i>                                                    |                                                                                                      | 24D. ADDRESS<br><i>Baltimore, Maryland 21224</i>                                              |                                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 15 1972</i>                                                                                                                                                                                                                                                                                                        |                         | 25B. NAME OF REGISTRAR<br><i>Edney Johnston</i>                                                                                                  |                                                    | 25C. FUNERAL DIRECTOR<br><i>Choy Wilson</i>                                                                          |                                                                                                      | ADDRESS<br><i>1000 Bland St.</i>                                                              |                                              |

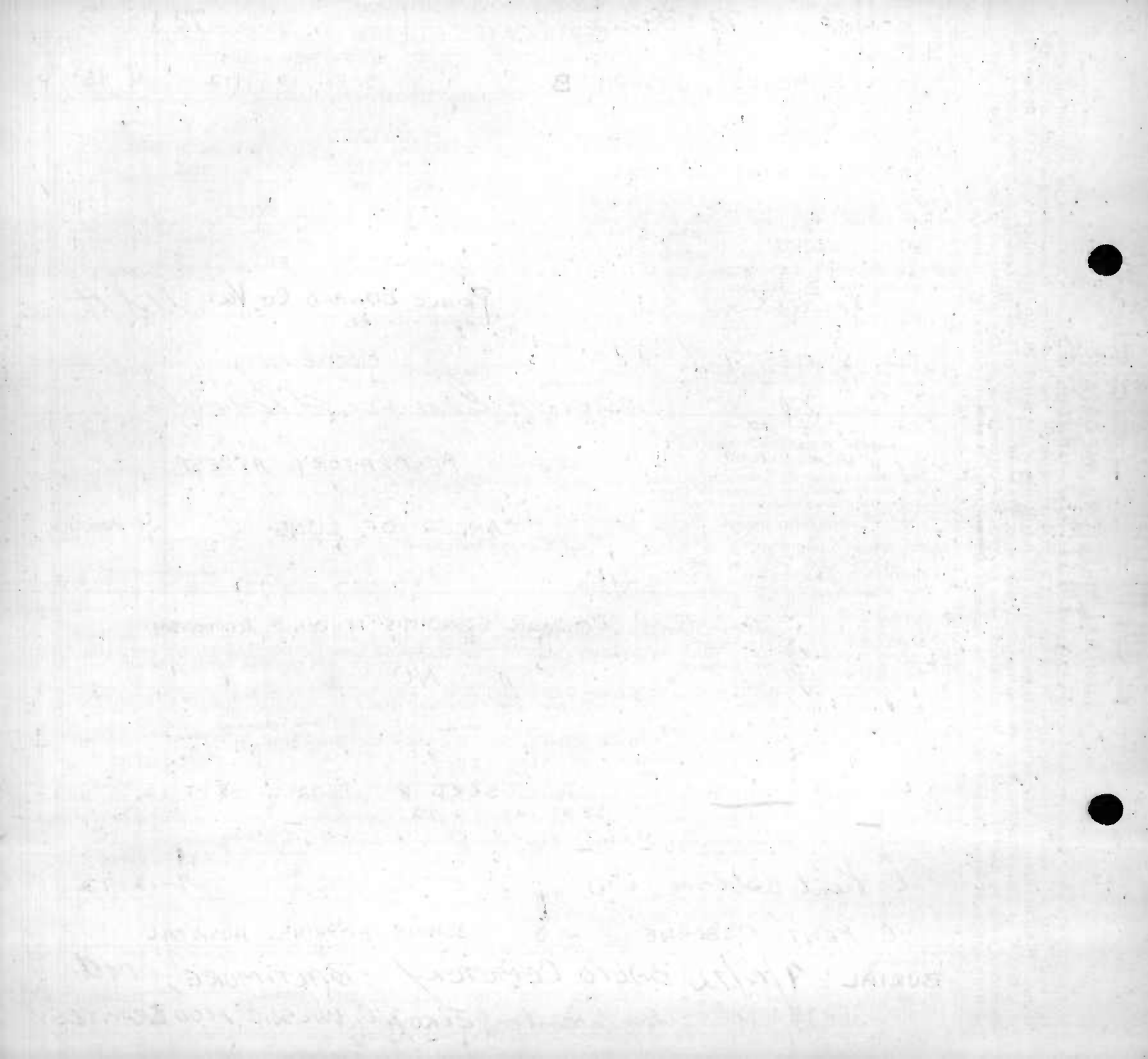




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                            | REG. NO. <b>72 08832</b>                                                   |                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| E-355 72 18862                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                            | STATE OF MARYLAND-DHMH                                                     |                                                                                                                                 |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                            | CERTIFICATE OF DEATH                                                       |                                                                                                                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <b>EDMONDS, JOSEPH B.</b>                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>SEPT. 12, 1972 4:45 P.M.</b>                                                                               |                                                                            |                                                                                                                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2654</b> |                                                                            |                                                                                                                                 |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b><br><b>33</b>                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                        |                                                                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | E. STREET AND NUMBER<br><b>5917 LA CLEDE ROAD</b>                                                                                          |                                                                            |                                                                                                                                 |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>NEGRO</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>06-22-16</b>                                                                                                        | 9. AGE (In years last birthday)<br><b>56</b>                               | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                                                                                                        |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                            | 11. BIRTHPLACE (State or foreign country)<br><b>PRINCE EDWARD Co., Va.</b> |                                                                                                                                 |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 13. FATHER'S NAME<br><b>LEE EDMONDS</b>                                                                                                    |                                                                            |                                                                                                                                 |
| 14. MOTHER'S MAIDEN NAME<br><b>CARRIE BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                      |                                                                            |                                                                                                                                 |
| 16. SOCIAL SECURITY NO.<br><b>250-20-1979</b>                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 17. INFORMANT<br><b>Emma F. Edwards</b>                                                                                                    |                                                                            |                                                                                                                                 |
| 18. CAUSE OF DEATH<br><b>462.141 303.2</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>RESPIRATORY ARREST</b><br><b>CANCER OF LUNG</b> |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 MONTHS.</b>                                                                           |                                                                            |                                                                                                                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>CHRONIC BRONCHITIS, CHRONIC ALCOHOLISM</b>                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                                                            |                                                                            |                                                                                                                                 |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                            | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                     |                                                                                                                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                       |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                                                                                                                 |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                            |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                            | 21F. HOW DID INJURY OCCUR?                                                 |                                                                                                                                 |
| 22. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 8 1972</b> to <b>SEPT 12 1972</b> , that (I) (we) lost saw the deceased alive on <b>SEPT 12 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                             |                         |                                                                                                                                                             |                                                                                                                                            |                                                                            |                                                                                                                                 |
| 23A. SIGNATURE<br><b>C. Kent Osborne M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><b>9-12-72</b>                                                                                                         |                                                                            | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><b>C. KENT OSBORNE M.D.</b>                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 23D. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                              |                                                                            |                                                                                                                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                            |                         | 24B. DATE<br><b>9/16/72</b>                                                                                                                                 |                                                                                                                                            | 24C. NAME of CEMETERY or CREMATORY<br><b>BALTO CEMETERY</b>                |                                                                                                                                 |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                                                                                                               |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                       |                                                                                                                                            |                                                                            |                                                                                                                                 |
| 25B. NAME OF REGISTRAR<br><b>Lidney Johnston</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         | 25C. FUNERAL DIRECTOR<br><b>ELROY O. WILSON 1000 BRANTLEY AVE</b>                                                                                           |                                                                                                                                            |                                                                            |                                                                                                                                 |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08863

BIRTH NO.

STATE OF MARYLAND-DHMH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>THEODORE JOHNSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.                              |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1224 Argyle Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>September 10, 1972</b> Hour <b>8:30 A.</b> M.                                           |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7. RACE<br><b>Negro</b>                                                                                                                 |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1703</b> |  |
| 9. DATE OF BIRTH<br><b>7-19-1920</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10. AGE (In years last birthday) <b>52</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                    |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTO. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                                                                               |  |
| 13. FATHER'S NAME<br><b>HENRY RUSSUM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                              |  |
| 15. MOTHER'S MAIDEN NAME<br><b>SOHPRONIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YN</b>                    |  |
| 17. SOCIAL SECURITY NO.<br><b>215-13-9425</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 18. INFORMANT<br><b>ISABELLE JOHNSON</b> ADDRESS <b>565. MONASTERY</b> <b>AVG</b>                                                       |  |
| 19. <b>571.9</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cirrhosis of liver</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                            |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes (partial)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                               |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> (partial) Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>9/10/72</b><br>EXAMINER'S NAME (Type) |  |                                                                                                                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24B. DATE<br><b>9-14-72</b>                                                                                                             |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>MT. AUBURN CEM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. Md.</b>                                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 25B. NAME OF REGISTRAR<br><b>Sidney Johnson</b>                                                                                         |  |
| 25C. FUNERAL DIRECTOR<br><b>Eugene J. Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><b>1000 BRANTLEY</b> <b>AVG</b>                                                                                              |  |

Henry Johnson  
Soprano

1-14-1920  
Barto

BRUNN 8-14-20 Mr. Johnson  
Barto

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                                          |                                     |                                                                                                                                |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| C-200 72 08864                                                                                                                                                                                                                                                                                                                                        |                     | BALTIMORE CITY HEALTH DEPT.                                                                                                                                              |                                     | REG. NO. 72-8864                                                                                                               |                                                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                             |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>PAULINE COX</b>                                                                                                                |                                     | 2. DATE AND HOUR OF DEATH<br><b>9/12/72 7:00 P.M.</b>                                                                          |                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2716</b>                               |                                     | C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SINAI HOSPITAL OF BALTIMORE</b><br><b>2 BALTIMORE MD. 21215</b>                                                                                                                                                                                                                                            |                     | E. STREET AND NUMBER<br><b>2427 W. COLDSRING LANE. 21215</b>                                                                                                             |                                     | F. STREET AND NUMBER                                                                                                           |                                                             |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><b>B</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>              | 8. DATE OF BIRTH<br><b>12/14/32</b> | 9. AGE (In years last birthday) <b>39</b>                                                                                      | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FOOD SERVICE</b>                                                                                                                                                                                                                                    |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PUBLIC SCHOOLS</b>                                                                                                               |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, VIRGINIA</b>                                                       |                                                             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                            |                     | 13. FATHER'S NAME<br><b>JOHN DICKERSON</b>                                                                                                                               |                                     | 14. MOTHER'S MAIDEN NAME<br><b>MARY CARR</b>                                                                                   |                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                 |                     | 16. SOCIAL SECURITY NO.<br><b>121 28 9368</b>                                                                                                                            |                                     | 17. INFORMANT<br><b>THOMAS E COX 2427 W COLDSRING LANE</b>                                                                     |                                                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE RESPIRATORY INSUFF</b><br><b>LYMPHANGIO CARCINOMATOSIS OF THE LUNGS</b>                                                                |                     | 19. CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>2NDARY TO</b><br><b>TNE LUNGS</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>                                                                  |                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                |                     |                                                                                                                                                                          |                                     |                                                                                                                                |                                                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |                                     | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                         |                                                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                 |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                  |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                       |                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                             |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                   |                                     | 21F. HOW DID INJURY OCCUR                                                                                                      |                                                             |
| 22. I certify that (1) (this hospital) attended the deceased from <b>9/11</b> 19 <b>72</b> to <b>9/12</b> 19 <b>72</b> that (4) (we) last saw the deceased alive on <b>9/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                                          |                                     |                                                                                                                                |                                                             |
| 23A. SIGNATURE<br><b>Thomas E Cox</b>                                                                                                                                                                                                                                                                                                                 |                     | 23B. DATE SIGNED<br><b>9/12/72</b>                                                                                                                                       |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>B. K. ERZNER M.D.</b>                                                                       |                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                             |                     | 24B. DATE<br><b>9/17/72</b>                                                                                                                                              |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>ROCKY MOUNT CEMETERY</b>                                                              |                                                             |
| 24D. LOCATION (City, town, or county) (State)<br><b>CUMBERLAND (CUMBERLAND) Va.</b>                                                                                                                                                                                                                                                                   |                     | 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                          |                                     | 25B. NAME OF REGISTRAR<br><b>LEWIS T. GWYNN</b>                                                                                |                                                             |
| 25C. FUNERAL DIRECTOR ADDRESS<br><b>4517 PARK HEIGHTS AVE.</b>                                                                                                                                                                                                                                                                                        |                     | 25D. FUNERAL DIRECTOR ADDRESS                                                                                                                                            |                                     |                                                                                                                                |                                                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-316 72 08865                                                                                                                                                                                                                                                                      |  |                      |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                            |  | 72 08865                                                                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|-------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                           |  |                      |  | CERTIFICATE OF DEATH                                                                                        |  |                                                                                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                              |  |                      |  | 2. DATE AND HOUR OF DEATH                                                                                   |  |                                                                                                                                 |  |
| Nettiferd, Louise                                                                                                                                                                                                                                                                   |  |                      |  | 9-13-72 at 5:40 PM                                                                                          |  |                                                                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                              |  |                      |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE B. COUNTY |  |                                                                                                                                 |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Dukeland Nursing Home                                                                                                                                                  |  |                      |  | Md. 25-62                                                                                                   |  |                                                                                                                                 |  |
| 5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                             |  |                      |  | C. CITY OR TOWN<br>Baltimore                                                                                |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                         |  |                      |  | B. DATE OF BIRTH<br>4/10/1877 94 yrs.                                                                       |  | 9. AGE (In years last birthday)                                                                                                 |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                   |  |                      |  | 11. BIRTHPLACE (State or foreign country)<br>Warsaw, Virginia                                               |  | 12. CITIZEN OF WHAT COUNTRY<br>U.S.                                                                                             |  |
| 13. FATHER'S NAME<br>Unknown                                                                                                                                                                                                                                                        |  |                      |  | 14. MOTHER'S MAIDEN NAME<br>Unknown                                                                         |  |                                                                                                                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                            |  |                      |  | 16. SOCIAL SECURITY NO.<br>220-56-0505                                                                      |  | 17. INFORMANT<br>R. Logan L.P.N.                                                                                                |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>436.91                                                                        |  |                      |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>CVA<br>DUE TO, OR AS A CONSEQUENCE OF:                             |  | ADDRESS<br>Nursing<br>Dukeland Home                                                                                             |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                      |  |                      |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                    |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                              |  |                      |  | 19A. DATE OF OPERATION                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                               |  |                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                        |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                           |  |                      |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?                                                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                      |  |                                                                                                             |  |                                                                                                                                 |  |
| 23A. SIGNATURE<br>Phillip E. Byrd, Jr. MD                                                                                                                                                                                                                                           |  |                      |  |                                                                                                             |  | 23B. DATE SIGNED<br>9/13/72                                                                                                     |  |
| 23C. PHYSICIAN'S NAME (Type)<br>PHILLIP E. BYRD, Jr. MD                                                                                                                                                                                                                             |  |                      |  | 23D. ADDRESS<br>2702 HANSON AVE.                                                                            |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                  |  | 24B. DATE<br>9-16-72 |  | 24C. NAME of CEMETERY or CREMATORY<br>Mt Calvary Cemetery                                                   |  | 24D. LOCATION (City, town, or county) (State)<br>Anne Arundel Cty., Md.                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 15 1972                                                                                                                                                                                                                                      |  |                      |  | 25B. NAME OF REGISTRAR<br>Wm C March                                                                        |  | 25C. FUNERAL DIRECTOR ADDRESS<br>928 E North Ave.                                                                               |  |





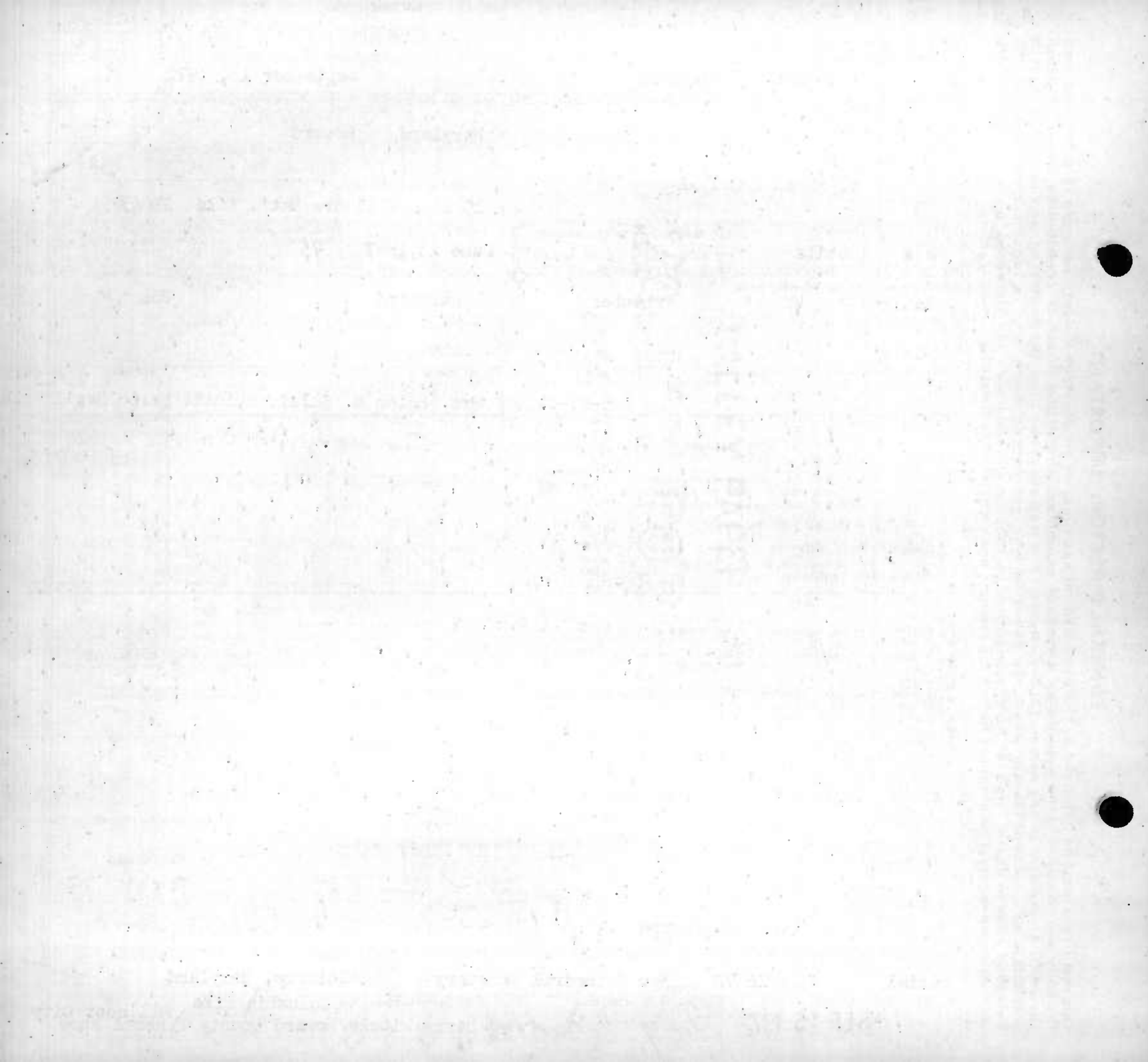
| STATE OF MARYLAND - DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| REG. NO. 72 08866                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>A. Edward McIntosh</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                               |                                        |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>9</b> Day <b>13</b> Year <b>72</b> Hour <b>M.</b> |                                             |  |                                                                                    |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1115 Edmondson Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                               |                                        |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month <b>9</b> Day <b>13</b> Year <b>72</b> Hour <b>11:00 a.</b> M.                                                              |                                             |  |                                                                                    |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>805</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE<br><b>Negro</b>                       |                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                             | C. CITY OR TOWN<br><b>Balto.</b>            |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>6-15-91</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10. AGE (In years last birthday)<br><b>81</b> |                                        | 11. BIRTHPLACE (State or foreign country)<br><b>Jamaica, W. Indies</b>                                                                                      |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | E. STREET AND NUMBER<br><b>1637 E. 25th Street</b>                                 |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Longshoreman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                               |                                        |                                                                                                                                                             | 13. FATHER'S NAME<br><b>Benjamin McIntosh</b>                                                                                                               |                                             |  |                                                                                    |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Longshoreman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                               |                                        |                                                                                                                                                             | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                             |  |                                                                                    |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Christine</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                               |                                        |                                                                                                                                                             | 17. SOCIAL SECURITY NO.<br><b>081-10-0405</b>                                                                                                               |                                             |  |                                                                                    |  |
| 18. INFORMANT<br><b>Ellen E. McIntosh</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                               |                                        |                                                                                                                                                             | ADDRESS<br><b>1637 E. 25th Street</b>                                                                                                                       |                                             |  |                                                                                    |  |
| 19. <b>412.41</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                        |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 20A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 21. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                               |                                        |                                                                                                                                                             | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                             |  |                                                                                    |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                               |                                        |                                                                                                                                                             | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                      |                                             |  |                                                                                    |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>9/13/72</b><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             |                                             |  |                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                               | 24B. DATE<br><b>9-18-72</b>            |                                                                                                                                                             | 24C. NAME OF CEMETERY or CREMATORY<br><b>Louden Park Cemetery</b>                                                                                           |                                             |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltol, Md.</b>                |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                               | 25B. NAME OF REGISTRAR<br><b>72000</b> |                                                                                                                                                             |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><b>Wm. C March</b> |  |                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                               |                                        |                                                                                                                                                             |                                                                                                                                                             | ADDRESS<br><b>928 E North Ave.</b>          |  |                                                                                    |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

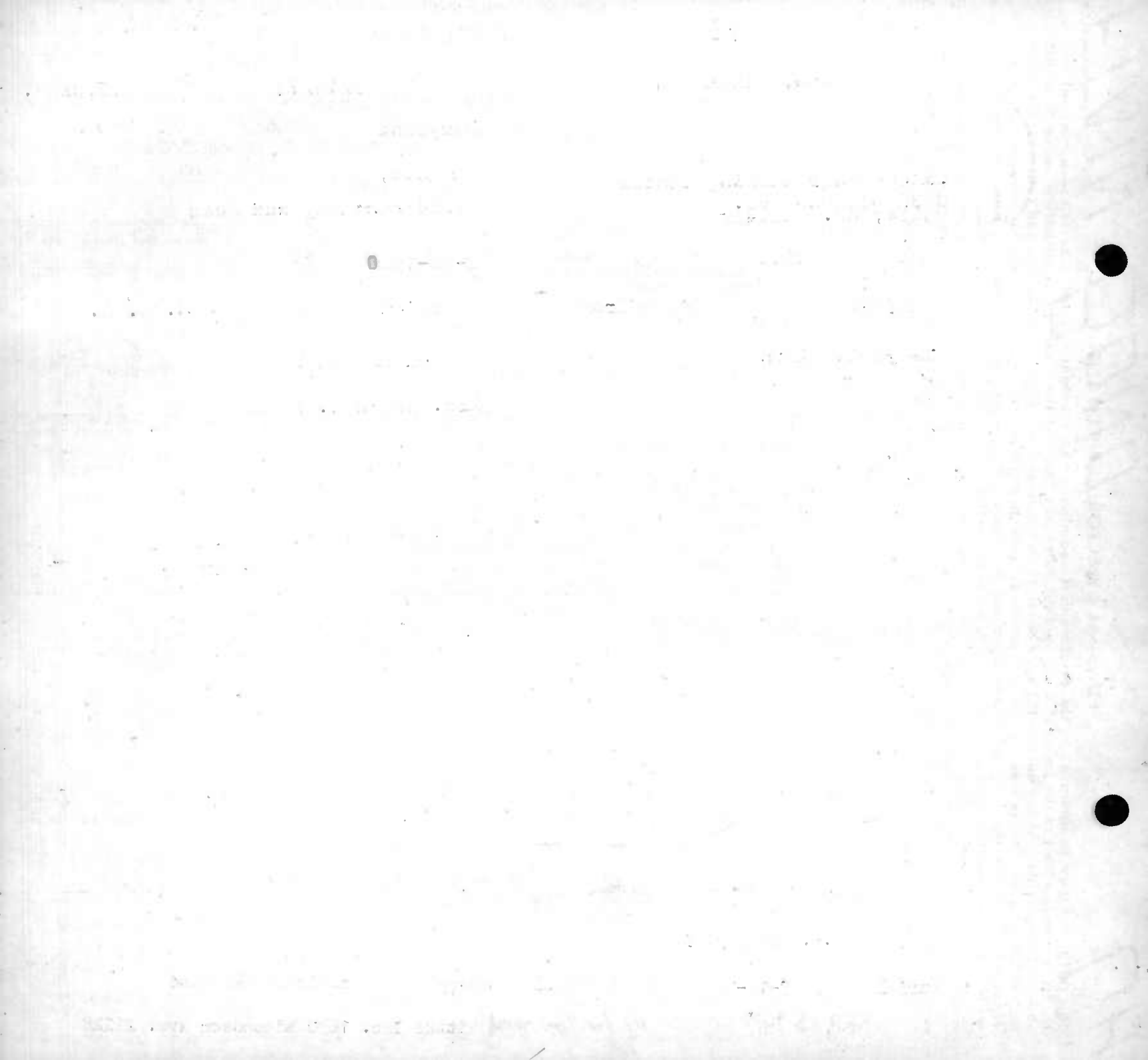
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                                                                                                                        |                                          | REG. NO. 72 08867                                                        |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| 72 08867                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                                                                                                                                        |                                          | STATE OF MARYLAND-DHMH                                                   |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>James Sullivan</b>                                                                                                                                                                                                           |                                          | 2. DATE AND HOUR OF DEATH<br><b>September 13, 1972</b>                   |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40 ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Howard</b><br>C. CITY OR TOWN <b>6300</b> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                          | E. STREET AND NUMBER<br><b>10414 Baltimore Nat'l Pike 21043</b>          |                                                           |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                            | 8. DATE OF BIRTH<br><b>June 26, 1897</b> | 9. AGE (In years lost birthday)<br><b>75</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Carpenter</b>                                                                                                                                                                                                                  |                                          | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 13. FATHER'S NAME<br><b>late</b>                                                                                                                                                                                                                                       |                                          | 14. MOTHER'S MAIDEN NAME<br><b>late</b>                                  |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 16. SOCIAL SECURITY NO.<br><b>219-07-1735</b>                                                                                                                                                                                                                          |                                          | 17. INFORMANT<br><b>Mrs. Helen G. Sullivan 10414 Balto Nat'l Pike</b>    |                                                           |
| 18. <b>412.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Atherosclerotic Cardiovascular Disease</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Chronic Emphysema</b> |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 Yrs</b>                                                                                                                                                                                                          |                                          |                                                                          |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                       |                                          | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                               |                                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>                                                                                                                                                              |                                          | 21F. HOW DID INJURY OCCUR?                                               |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8-17</b> 19 <b>59</b> to <b>9-13</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>8-19</b> 19 <b>72</b> and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                            |                         |                                                                                                                                                                                                                                                                        |                                          |                                                                          |                                                           |
| 23A. SIGNATURE<br><b>Peter Van Thorpe MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                                                                                                                                        |                                          | 23B. DATE SIGNED<br><b>9-14-72</b>                                       |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Peter Van Thorpe MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                                                                                                                                        |                                          | 23D. ADDRESS<br><b>3459 St. Johns Lane, Ellicott City, Md.</b>           |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 24B. DATE<br><b>9/16/72</b>                                                                                                                                                                                                                                            |                                          | 24C. NAME OF CEMETERY or CREMATORY<br><b>New Cathedral Cemetery</b>      |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                                                                                                                                  |                                          |                                                                          |                                                           |
| 25B. NAME OF REGISTRAR<br><b>Lidney Johnston</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 25C. FUNERAL DIRECTOR<br><b>Harry Witzke, Howard County Funeral Home</b>                                                                                                                                                                                               |                                          |                                                                          |                                                           |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                                                                                                                                                                                                                       | REG. NO. 72 08868                                                        |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| 72 08868                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                                                                                                                                                                                                                       | STATE OF MARYLAND-DHMH                                                   |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                               |                  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                                                                                                                                                                                                                       | 2. DATE AND HOUR OF DEATH                                                |                                                           |
|                                                                                                                                                                                                                                                                                                                                         |                  | Dixon, Singleton                                                                                                                                            |                                                                                                                                                                                                                       | 9/14/72 12:05 P.M.                                                       |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                 |                                                                          |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Caton Manor Nursing Center<br>3330 Wilkens Ave.<br>Balto., Md. 21229                                                                                                                                                                                                                            |                  |                                                                                                                                                             | A. STATE<br>Maryland<br>B. COUNTY<br>2864<br>C. CITY OR TOWN<br>Balto.<br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br>4528 Pen Lucy Road |                                                                          |                                                           |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                          | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>2-26-1880                                                                                                                                                                                         | 9. AGE (In years lost birthday)<br>92                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired                                                                                                                                                                                                                                  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>B&O Railroad                                                                                                           |                                                                                                                                                                                                                       | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    |                                                           |
| 13. FATHER'S NAME<br>Benjamin Dixon                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                                                                                                              |                                                                          |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                          |                  | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                                                                                                                                                                                                       | 14. MOTHER'S MAIDEN NAME<br>Susana Phipps                                |                                                           |
|                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                                                                                                                                                                                                       | 17. INFORMANT<br>Mrs. Helen C. Power                                     |                                                           |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Acute Pulmonary Edema<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>ASCV. disease<br>(C) _____                                                   |                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 hrs.    |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Smility                                                                                                                                                                                       |                  |                                                                                                                                                             |                                                                                                                                                                                                                       |                                                                          |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                       | 20A. AUTOPSY? (Yes or No)                                                |                                                           |
|                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                                                                                                                                                                                                       |                                                                          |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                          |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                               |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                       | 21F. HOW DID INJURY OCCUR?                                               |                                                           |
|                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                                                                                                                                                                                                       |                                                                          |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from 6/10 1972 to 9/14 1972, that (I) (we) last saw the deceased alive on 9/7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                |                  |                                                                                                                                                             |                                                                                                                                                                                                                       |                                                                          |                                                           |
| 23A. SIGNATURE<br>D.C. MacLaughlin                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |                                                                                                                                                                                                                       | 23B. DATE SIGNED<br>9/14/72                                              |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br>D.C. MacLaughlin                                                                                                                                                                                                                                                                                        |                  | 23D. ADDRESS<br>303 N. Rolling Rd 21228                                                                                                                     |                                                                                                                                                                                                                       |                                                                          |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                      |                  | 24B. DATE<br>9-18-72                                                                                                                                        |                                                                                                                                                                                                                       | 24C. NAME of CEMETERY or CREMATORY<br>New Cathedral Cemetery             |                                                           |
|                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                                                                                                                                                                                                       | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Maryland      |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 15 1972                                                                                                                                                                                                                                                                                          |                  | 25B. NAME OF REGISTRAR<br>Sidney W. Witzke                                                                                                                  |                                                                                                                                                                                                                       | 25C. FUNERAL DIRECTOR<br>Witzke Inc. 1630 Edmondson Ave. 21228           |                                                           |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO.

72 08869

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

COLIE MORGAN

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☒Month Day Year  
September 4, 1972Hour ?  
M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 2640 Boone Street

3. DATE  
PRONOUNCED DEADMonth Day Year  
September 4, 1972Hour 12:00 P.  
M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

904

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

1-15-07

10. AGE (In years  
lost birthday)

65

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2640 Boone Street

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF

WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Colie Morgan Sr

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sarah Carter

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Emily M. Andrews 2302 Barclay St

19.

412.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/5/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Burial 9-9-72

MX Calvary Cem &amp; Co Md

SEP 15 1972

Sidney Winston

Rayner Sanders 217 E. Preston St



1-12-07

U.S.A.

Returned

Col. M. J. Murphy  
Sergeant  
Capt. M. J. Murphy

Received 7-9-10 The Col. M. J. Murphy  
Sergeant



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08870

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Andrew G. Hoffmann</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>9 14 72 12:42 P.</b>                                                        |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Perring</b><br><b>5346 Perring Parkway</b>                                                                                                                                                                                                                                                                            |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>9 14 72 12:42 P.</b>                                                                                                                                 |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7. RACE<br><b>White</b>                                                                                                                                                                                   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                        |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                       |  |
| 9. DATE OF BIRTH<br><b>Nov. 23, 1899</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10. AGE (In years lost birthday)<br><b>72</b>                                                                                                                                                             |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                             |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Machinist</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br><b>Catherine Wittig</b>                                                                                                                                                       |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                            |  | 17. SOCIAL SECURITY NO.<br><b>213-01-6489</b>                                                                                                                                                             |  |
| 18. INFORMANT<br><b>Mrs. Marie Simonsen</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | ADDRESS<br><b>5346 Perring Parkway</b>                                                                                                                                                                    |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                              |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                          |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                    |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>home</b>                                                                                                   |  |
| 22D. TIME OF INJURY (APPROX.)<br>Month Day Year Hour<br><b>9 14 72 12:42 P.</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                      |  |
| 22C. WHERE DID IT (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>5346 Perring Parkway (basement)</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 22F. HOW DID INJURY OCCUR?<br><b>hanged self</b>                                                                                                                                                          |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                      |  |                                                                                                                                                                                                           |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>William P. Mulloy, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>9-15-72</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 24B. DATE<br><b>9-18-1972</b>                                                                                                                                                                             |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore County, Maryland</b>                                                                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 25B. NAME OF REGISTRAR<br><b>Sidney H. Wilson</b>                                                                                                                                                         |  |
| 25C. FUNERAL DIRECTOR<br><b>Lilly &amp; Zeiler Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS<br><b>1901-07 Eastern Ave.</b>                                                                                                                                                                    |  |

Nov. 23, 1909

Bellevue, Maryland

U.S.A.

Hoffman

Bellevue, Maryland

Bellevue, Maryland

113-01-6155 Mrs. Marie Hoffman 20th Street, Baltimore

Bellevue County, Maryland

Oct. 1909

9-18-1909

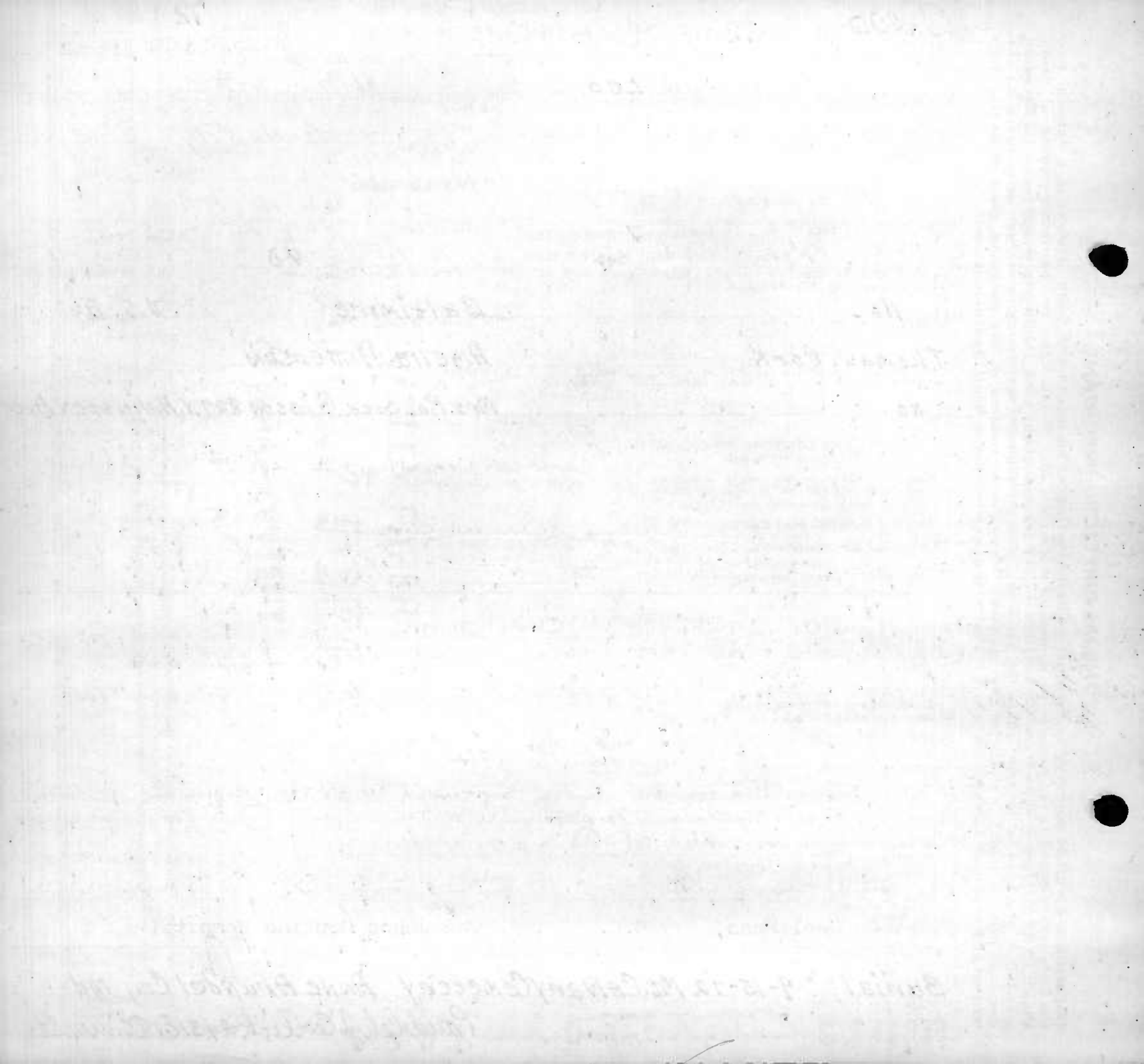
Bellevue

113-01-6155 Mrs. Marie Hoffman 20th Street, Baltimore

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                                  |                                     |                                                                                                                                            |                              |                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------|--|
| C-200                                                                                                                                                                                                                                                                                                                                                                           |                         | 72 08871                                                                                                                                                         |                                     | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                           |                              | REG. NO. 72 08871                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                                  |                                     | STATE OF MARYLAND-DEATH                                                                                                                    |                              |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Cook Edward Leo</i>                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                  |                                     | 2. DATE AND HOUR OF DEATH<br><i>9/11/72 6:45</i> M.                                                                                        |                              |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                                  |                                     | 4. USUAL RESIDENCE (Where deceased lived or institution: residence before admission)<br>A. STATE <i>MD</i> B. COUNTY <i>Baltimore City</i> |                              |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>33 Johns Hopkins Hospital</i>                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                                  |                                     | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                        |                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                                  |                                     | E. STREET AND NUMBER<br><i>1621 E. North Ave.</i>                                                                                          |                              | 806                                                                                           |  |
| 5. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                           | 6. RACE<br><i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>11/06/31</i> | 9. AGE (in years lost birthday)<br><i>40</i>                                                                                               | If Under 1 Yr. Months: Oays: | If Under 24 Hrs. Hours: Min.                                                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>No</i>                                                                                                                                                                                                                                                                        |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                |                                     | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore</i>                                                                              |                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                 |  |
| 13. FATHER'S NAME<br><i>Thomas Cook</i>                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                                  |                                     | 14. MOTHER'S MAIDEN NAME<br><i>Amelia Anderson</i>                                                                                         |                              |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                                                                           |                         | 16. SOCIAL SECURITY NO.                                                                                                                                          |                                     | 17. INFORMANT<br><i>Mrs. Rosetta Gibson 827 N. Arlington Ave.</i>                                                                          |                              |                                                                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) - stating the UNDERLYING CONDITION last.                                          |                         |                                                                                                                                                                  |                                     | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Gram Negative Sepsis</i>                                                      |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>24 hours</i>                               |  |
| (B) <i>sickle cell crisis</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                                  |                                     | (C) _____                                                                                                                                  |                              |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><i>Cholelithiasis</i>                                                                                                                                                                                                                 |                         |                                                                                                                                                                  |                                     |                                                                                                                                            |                              |                                                                                               |  |
| 19A. DATE OF OPERATION<br><i>2/1</i>                                                                                                                                                                                                                                                                                                                                            |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                 |                                     | 20A. AUTOPSY? (Yes or No)<br><i>Yes</i>                                                                                                    |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>NO</i>             |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                         |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                |                              |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                       |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                        |                                     | 21F. HOW DID INJURY OCCUR?                                                                                                                 |                              |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>September 10</i> 19 <i>72</i> to <i>September 11</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>September 11</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                                  |                                     |                                                                                                                                            |                              |                                                                                               |  |
| 23A. SIGNATURE<br><i>Joel Moss MD</i>                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                                  |                                     | 23B. DATE SIGNED<br><i>September 11, 1972</i>                                                                                              |                              |                                                                                               |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Joel Moss, M.D.</i>                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                                  |                                     | 23D. ADDRESS<br><i>The Johns Hopkins Hospital</i>                                                                                          |                              |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                       |                         | 24B. DATE<br><i>9-15-72</i>                                                                                                                                      |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><i>Mt. Calvary Cemetery</i>                                                                          |                              | 24D. LOCATION (City, town, or county) (State)<br><i>Anne Arundel Co., Md.</i>                 |  |
| 24E. NAME REC'D. BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                |                         | 25B. NAME OF REGISTRAR<br><i>Dorothy Johnson</i>                                                                                                                 |                                     | 25C. FUNERAL DIRECTOR<br><i>Randolph Collick</i>                                                                                           |                              | ADDRESS<br><i>2431 E. Oliver St.</i>                                                          |  |
| SEP 15 1972                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                                  |                                     |                                                                                                                                            |                              |                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                                                                                                                                                                                          |                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>C-500</span> <span>72 08872</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>72 08872</span> </div>                                                                                         |                                                                                                           |                                                                                                                                                                                                                                                                                                                          |                                                                                                        |
| BIRTH NO.<br>1. NAME OF DECEASED<br>(Type or Print) <b>CONAWAY, LESLIE E.</b>                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 2. DATE AND HOUR OF DEATH<br><b>SEPTEMBER 12, 1972 2:30 P.M.</b>                                                                                                                                                                                                                                                         |                                                                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><div style="text-align: center; font-size: 2em;">00</div> <b>ST. AGNES HOSPITAL</b>                                                                                                                                                               |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>HOWARD</b><br>C. CITY OR TOWN <b>SYKESVILLE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>SYKESVILLE MD. 21784</b> |                                                                                                        |
| 5. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                           | 6. RACE <b>CAUCASIAN</b>                                                                                  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                              | 8. DATE OF BIRTH <b>04 28 01</b>                                                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STEEL WORK Mechanic</b>                                                                                                                                                                                                                                                                                                    |                                                                                                           | 10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>                                                                                                                                                                                                                                                                           | 9. AGE (In years last birthday) <b>71</b><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY? <b>U/S/A</b>                                                                                                                                                                                                                                                                                |                                                                                                        |
| 13. FATHER'S NAME <b>CONAWAY</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 14. MOTHER'S MAIDEN NAME <b>NOT KNOWN TO INFORM.</b>                                                                                                                                                                                                                                                                     |                                                                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES WW1</b>                                                                                                                                                                                                                                                                                                   |                                                                                                           | 16. SOCIAL SECURITY NO. <b>213011091</b>                                                                                                                                                                                                                                                                                 |                                                                                                        |
| 17. INFORMANT <b>WILKENS &amp; CATON AVE.</b>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 17. ADDRESS <b>ST AGNES HOSPITAL RECORDS-</b>                                                                                                                                                                                                                                                                            |                                                                                                        |
| 18. <b>571191</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)<br><b>Cirrhosis of Liver</b>                                                                                                                                                                             |                                                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                             |                                                                                                        |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                              |                                                                                                           | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                        |                                                                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                                                                                                                                                                                          |                                                                                                        |
| 19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                 |                                                                                                        |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                    | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                               |                                                                                                        |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>AUGUST 31 72</b> to <b>SEPTEMBER 12 19 72</b> , that <b>XIX</b> (we) last saw the deceased alive on <b>SEPTEMBER 12 19 72</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death. |                                                                                                           |                                                                                                                                                                                                                                                                                                                          |                                                                                                        |
| 23A. SIGNATURE <b>E. H. HENZAN M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 23B. DATE SIGNED <b>9/12/72</b>                                                                                                                                                                                                                                                                                          |                                                                                                        |
| 23C. PHYSICIAN'S NAME (Type) <b>EITATSU. HENZAN</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           | 23D. ADDRESS                                                                                                                                                                                                                                                                                                             |                                                                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                     | 24B. DATE <b>9-15-72</b>                                                                                  | 24C. NAME OF CEMETERY OR CREMATORY <b>Mission Lutheran Cemetery</b>                                                                                                                                                                                                                                                      | 24D. LOCATION (City, town, or county) (State) <b>Sykesville Carroll Md.</b>                            |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 15 1972</b>                                                                                                                                                                                                                                                                                                                                                                           | 25B. NAME OF REGISTRAR <b>Sidney H. Houghton</b>                                                          | 25C. FUNERAL DIRECTOR <b>Harry W. Houghton</b>                                                                                                                                                                                                                                                                           | 25D. ADDRESS <b>Sykesville, Md.</b>                                                                    |

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1. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

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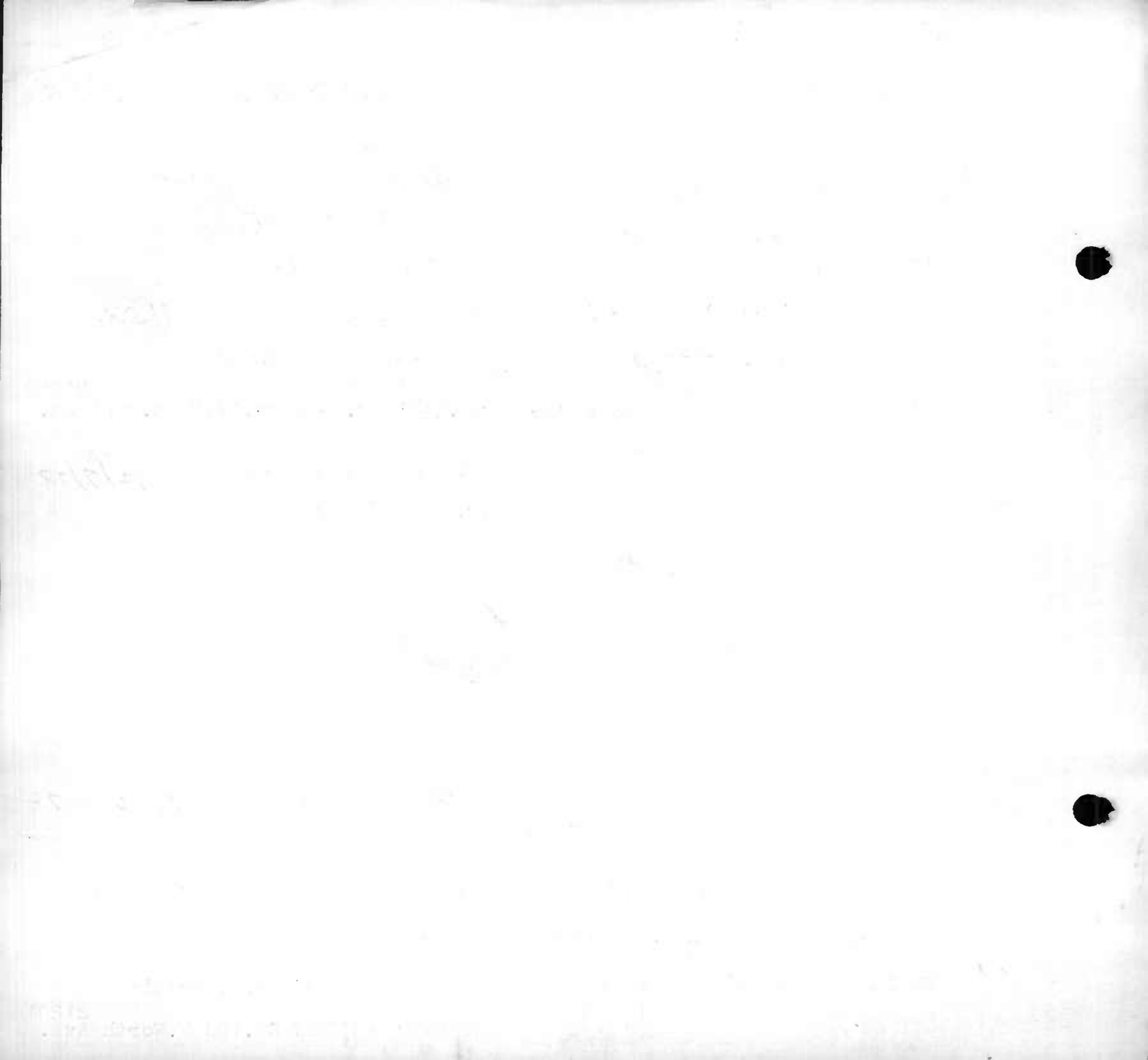
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>72 08873<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                   |  | REG. NO. 72 08873<br>STATE OF MARYLAND-DEMH                                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                   |  | 1. NAME OF DECEASED<br>(Type or Print) <i>LAWRENCE Abbott Snyder</i>                                                                                                                                                                                                                                                              |  | 2. DATE AND HOUR OF DEATH<br><i>Sept-13-1972 11:05 P.M.</i>                                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><i>Bolton Hill Nursing Home</i>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MARYLAND</i><br>B. COUNTY <i>1205</i>                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Bolton Hill Nursing Home</i>                                                                                                                                                                                                                                                                                                                                     |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                              |  | C. CITY OR TOWN<br><i>BALTIMORE</i><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |
| E. STREET AND NUMBER<br><i>1712 ST. PAUL ST.</i>                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX <i>male</i> 6. RACE <i>white</i>                                                                                                                                                                                                                                                                                           |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><i>7-2-98</i>                                                                                                                                                                                                                                                                                                                                                                           |  | 9. AGE (in years last birthday)<br><i>74</i>                                                                                                                                                                                                                                                                                      |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>ENGINEER(Ret'd)</i>                                                                                                                                                                                                                                                                                       |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>MARINE</i>                                                                                                                                                                                                                                                                                |  | 11. BIRTHPLACE (State or foreign country)<br><i>MARYLAND</i>                                                                                                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                                                                                                                                                                                                                                                               |  | 13. FATHER'S NAME<br><i>Edward P. Snyder</i>                                                                                                                                                                                                                                                                                      |  | 14. MOTHER'S MAIDEN NAME<br><i>Martha Jane Young</i>                                                                                                        |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                                                                                                       |  | 16. SOCIAL SECURITY NO. A<br><i>228-18-7269</i>                                                                                                                                                                                                                                                                                   |  | 17. INFORMANT: <i>wife</i> ADDRESS <i>21202</i><br><i>Mrs. Sybil H. Snyder, 1712 St. Paul St.</i>                                                           |  |
| 18. <i>12/17/72</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>Brown's Disease</i><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>with metastases</i> |  |                                                                                                                                                                                                                                                                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>12/17/72</i>                                                                                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br><i>9/13/72</i>                                                                                                                                                                                                                                                                                                                                                                    |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                  |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                        |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                    |  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                         |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |  |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                  |  | 22. I certify that (I) (this hospital) attended the deceased from <i>8/20/72</i> to <i>9/13/72</i> that (I) (we) last saw the deceased alive on <i>9/13</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                        |  | 23B. DATE SIGNED<br><i>9/13/72</i>                                                                                                                                                                                                                                                                                                |  | 23C. PHYSICIAN'S NAME (Type)<br><i>Dr. Van H. M. H. M.</i>                                                                                                  |  |
| 23D. ADDRESS<br><i>21202 St. Paul St. Baltimore</i>                                                                                                                                                                                                                                                                                                                                                         |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>                                                                                                                                                                                                                                                                         |  | 24B. DATE<br><i>9/16/72</i>                                                                                                                                 |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><i>Forest Lawn</i>                                                                                                                                                                                                                                                                                                                                                    |  | 24D. LOCATION (City, town, or county) (State)<br><i>Norfolk, Virginia</i>                                                                                                                                                                                                                                                         |  | 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 15 1972</i>                                                                                                       |  |
| 25B. NAME OF REGISTRAR<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                |  | 25C. FUNERAL DIRECTOR<br><i>STEWART &amp; MOWEN CO.</i>                                                                                                                                                                                                                                                                           |  | ADDRESS <i>21201</i><br><i>108 W. North Ave.</i>                                                                                                            |  |

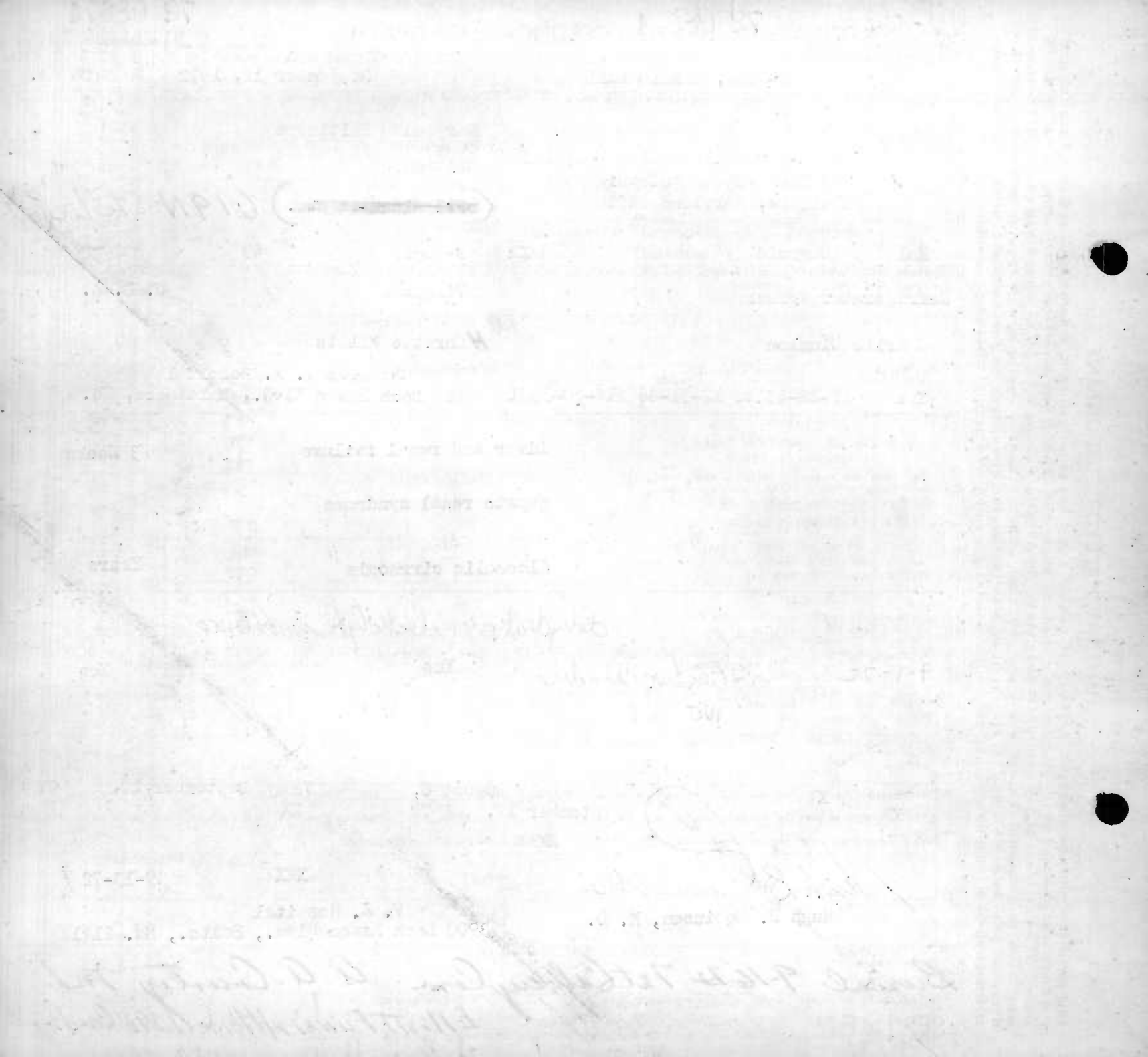




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                       |  |                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| W-524                                                                                                                                                                                                                                                                                                                   |  | 72 08874                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |  | REG. NO. 72 08874                                                                                                                                           |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  | STATE OF MARYLAND-DEME                                                                |  |                                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH                                                             |  |                                                                                                                                                             |  |
| WINSLOW, WILLIE EARL                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | September 12, 1972 7:00 A.M.                                                          |  |                                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>23 Veterans Administration Hospital<br>3900 Loch Raven Boulevard<br>Baltimore, Maryland 21218                                                                                                           |  |                                                                                                           |  | A. STATE B. COUNTY<br>Maryland Baltimore 501                                          |  |                                                                                                                                                             |  |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 6. RACE<br>Negroid                                                                    |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>9-23-23                                                                                                                                                                                                                                                                                             |  | 9. AGE (In years last birthday)<br>49 48                                                                  |  | 10. UNDER 1 Yr. Months: Days: Hrs. Min.                                               |  | 11. BIRTHPLACE (State or foreign country)<br>Virginia                                                                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Refrigerator Worker                                                                                                                                                                                                      |  |                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                                                    |  |
| 13. FATHER'S NAME<br>Charlie Winslow                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br>Henretta Willis                                           |  |                                                                                                                                                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) Yes                                                                                                                                                                                                                                                |  |                                                                                                           |  | 16. SOCIAL SECURITY NO.<br>11-26-43 to 12-31-46 214-20-3561                           |  | 17. INFORMANT Records V. A. Hospital ADDRESS<br>3900 Loch Raven Blvd., Baltimore, Md.                                                                       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br>5 71.0 I<br>Liver and renal failure                                                                               |  |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 Weeks                               |  |                                                                                                                                                             |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                          |  |                                                                                                           |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Hepato renal syndrome       |  |                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>Alcoholic cirrhosis<br>Years                   |  |                                                                                                                                                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>dehydration & electrolyte imbalance                                                                                                                                           |  |                                                                                                           |  |                                                                                       |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br>9-1-72                                                                                                                                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>obstructive jaundice                                  |  | 20A. AUTOPSY? (Yes or No)<br>Yes                                                      |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                                                                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>NO                                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)           |  |                                                                                                                                                             |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                            |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                            |  |                                                                                                                                                             |  |
| 22. I certify that (this hospital) attended the deceased from August 8, 19 72 to September 12, 19 72, that (we) lost saw the deceased alive on September 12, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                       |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br>Hugh B. Robinson, M.D.                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 23B. DATE SIGNED<br>9-13-72                                                           |  | 23C. PHYSICIAN'S NAME (Type)<br>Hugh B. Robinson, M.D.                                                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                      |  | 24B. DATE<br>9-16-72                                                                                      |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.                                |  | 24D. LOCATION (City, town, or county) (State)<br>A. A. County Md.                                                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 15 1972                                                                                                                                                                                                                                                                          |  | 25B. NAME OF REGISTRAR<br>Sidney Winston                                                                  |  | 25C. FUNERAL DIRECTOR<br>Elliot Funeral Home                                          |  | 25D. ADDRESS<br>129 N. Calhoun St.                                                                                                                          |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

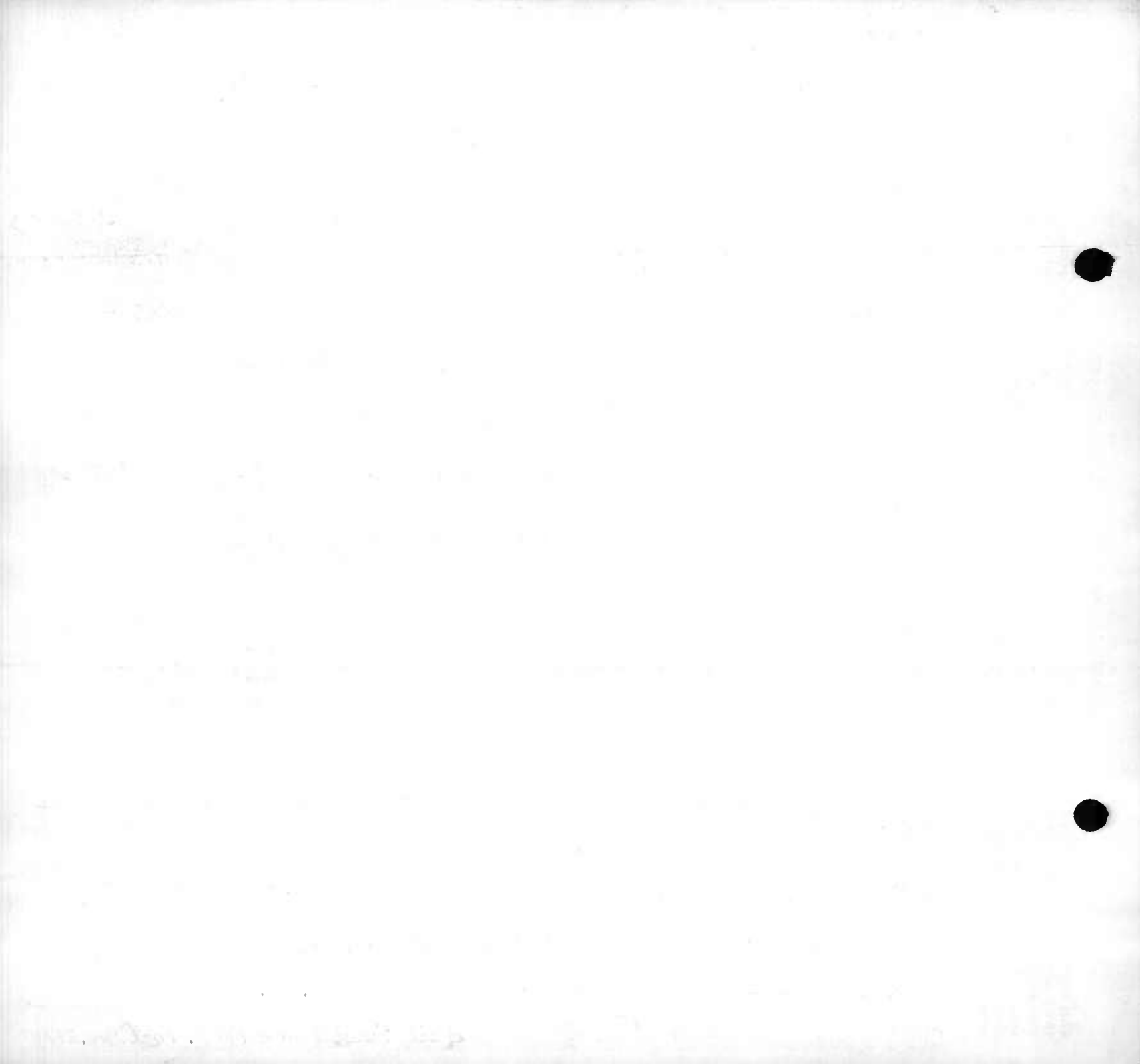
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | REG. NO. 72 08875                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| BIRTH NO. B-632                                                                                                                                                                                                                                                                                                     |  |                                                                                          |  | 72 08875                                                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                              |  |                                                                                          |  | 2. DATE AND HOUR OF DEATH                                                             |  |
| JDA M BRADSHAW                                                                                                                                                                                                                                                                                                      |  |                                                                                          |  | sept 13, 72 2 <sup>00</sup> PM                                                        |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                              |  |                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                           |  |                                                                                          |  | A. STATE B. COUNTY                                                                    |  |
| South Baltimore General Hospital                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | Maryland Baltimore city 2534                                                          |  |
| 43                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | C. CITY OR TOWN D. INSIDE CITY LIMITS?                                                |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                           |  |                                                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  |
| E. STREET AND NUMBER                                                                                                                                                                                                                                                                                                |  |                                                                                          |  | 521 Annabel Ave                                                                       |  |
| 5. SEX                                                                                                                                                                                                                                                                                                              |  | 6. RACE                                                                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |
| male                                                                                                                                                                                                                                                                                                                |  | white                                                                                    |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                         |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 8. DATE OF BIRTH                                                                      |  |
| House wife                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | Feb 20, 1904                                                                          |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME                                                                 |  | 9. AGE (In years last birthday)                                                       |  |
| Charles sparkes                                                                                                                                                                                                                                                                                                     |  | MARY                                                                                     |  | 68                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                            |  | 16. SOCIAL SECURITY NO.                                                                  |  | 17. INFORMANT                                                                         |  |
|                                                                                                                                                                                                                                                                                                                     |  | 216 28 4230                                                                              |  | Robert E. Bradshaw 521 Annabel Ave 21225                                              |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |
| 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                              |  |                                                                                          |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                          |  |                                                                                          |  | Ascites, Ca. Pancrease                                                                |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                           |  |                                                                                          |  | obstructive jaundice                                                                  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)                                                                                                                                                                                  |  |                                                                                          |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                   |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |  |                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  |
| August 27, 72                                                                                                                                                                                                                                                                                                       |  |                                                                                          |  | obstructive jaundice                                                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                               |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                       |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                            |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                         |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 1, 1972 to Sept 13, 1972 that (I) (we) last saw the deceased alive on Sept 13, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                                       |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                      |  |                                                                                          |  | 23B. DATE SIGNED                                                                      |  |
| Rashid M. Gill                                                                                                                                                                                                                                                                                                      |  |                                                                                          |  | sept 13, 72                                                                           |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                        |  |                                                                                          |  | 23D. ADDRESS                                                                          |  |
| FRAMAN                                                                                                                                                                                                                                                                                                              |  |                                                                                          |  |                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                            |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY                                                    |  |
| Burial                                                                                                                                                                                                                                                                                                              |  | 9/16/72                                                                                  |  | Cedar Hill Cemetery                                                                   |  |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                       |  | 25A. DATE REC'D BY HEALTH DEPT.                                                          |  | 25B. NAME OF REGISTRAR                                                                |  |
| Ritchie Hwyay Brooklyn 21225                                                                                                                                                                                                                                                                                        |  | SEP 18 1972                                                                              |  | Sidney H. Hinton                                                                      |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                               |  | 25D. ADDRESS                                                                             |  | 25E. ADDRESS                                                                          |  |
| McCully                                                                                                                                                                                                                                                                                                             |  | 237 Patapsco Ave Balto                                                                   |  | 21225                                                                                 |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                    |  |  |  | 72 08876                                                                                       |  | 72 08876 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------------------|--|----------|--|
| D-120                                                                                                                                                                                                                                                                                               |  |  |  | 72 08876                                                                                       |  | 72 08876 |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                           |  |  |  | REG. NO.                                                                                       |  | 72 08876 |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                              |  |  |  | 2. DATE AND HOUR OF DEATH                                                                      |  |          |  |
| DAVIS LILLIAN M.                                                                                                                                                                                                                                                                                    |  |  |  | 9/16/72 5:04 A.M.                                                                              |  |          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                              |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)          |  |          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                           |  |  |  | A. STATE B. COUNTY                                                                             |  |          |  |
| North Charles General Hospital                                                                                                                                                                                                                                                                      |  |  |  | Md. 2302                                                                                       |  |          |  |
| 5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                             |  |  |  | C. CITY OR TOWN D. INSIDE CITY LIMITS?                                                         |  |          |  |
| F W                                                                                                                                                                                                                                                                                                 |  |  |  | BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                         |  |  |  | E. STREET AND NUMBER                                                                           |  |          |  |
| Housewife                                                                                                                                                                                                                                                                                           |  |  |  | 1535 MARSHALL ST. #21230                                                                       |  |          |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                   |  |  |  | 14. MOTHER'S MAIDEN NAME                                                                       |  |          |  |
| JOHN RAY                                                                                                                                                                                                                                                                                            |  |  |  | LOUISA BENSON                                                                                  |  |          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                            |  |  |  | 16. SOCIAL SECURITY NO.                                                                        |  |          |  |
| no                                                                                                                                                                                                                                                                                                  |  |  |  | 17. INFORMANT ADDRESS                                                                          |  |          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                  |  |  |  | CAUSE OF DEATH                                                                                 |  |          |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                        |  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                            |  |          |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                   |  |  |  | Cerebral hemorrhage 9 hrs                                                                      |  |          |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                           |  |  |  | (B) Arteriosclerosis, general                                                                  |  |          |  |
| II                                                                                                                                                                                                                                                                                                  |  |  |  | (C)                                                                                            |  |          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                    |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                   |  |          |  |
| 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                             |  |  |  | 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)                                                                                                                                                                                                              |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)       |  |          |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                            |  |  |  | 21D. TIME OF INJURY (Approx.)                                                                  |  |          |  |
| 21E. INJURY OCCURRED                                                                                                                                                                                                                                                                                |  |  |  | 21F. HOW DID INJURY OCCUR?                                                                     |  |          |  |
| 22. I certify that (1) (this hospital) attended the deceased from 9/15/72 to 9/16/72 that (1) (we) last saw the deceased alive on 9/16/72 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |  |  | 23A. SIGNATURE                                                                                 |  |          |  |
| 23B. DATE SIGNED                                                                                                                                                                                                                                                                                    |  |  |  | 23C. PHYSICIAN'S NAME (Type)                                                                   |  |          |  |
| 9/16/72                                                                                                                                                                                                                                                                                             |  |  |  | RONALD E. GILLILAN MD                                                                          |  |          |  |
| 23D. ADDRESS                                                                                                                                                                                                                                                                                        |  |  |  | 24A. BURIAL CREMATION, REMOVAL (Specify)                                                       |  |          |  |
| NORTH Charles General Hosp                                                                                                                                                                                                                                                                          |  |  |  | Burial                                                                                         |  |          |  |
| 24B. DATE                                                                                                                                                                                                                                                                                           |  |  |  | 24C. NAME OF CEMETERY or CREMATORY                                                             |  |          |  |
| 9-20-72                                                                                                                                                                                                                                                                                             |  |  |  | Glen Haven Cemetery                                                                            |  |          |  |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                       |  |  |  | 25A. DATE REC'D BY HEALTH DEPT.                                                                |  |          |  |
| Balto. Md.                                                                                                                                                                                                                                                                                          |  |  |  | SEP 18 1972                                                                                    |  |          |  |
| 25B. NAME OF REGISTRAR                                                                                                                                                                                                                                                                              |  |  |  | 25C. FUNERAL DIRECTOR ADDRESS                                                                  |  |          |  |
| McGully Funeral Home 130 E. Fort Ave. 21230                                                                                                                                                                                                                                                         |  |  |  | 25D. NAME OF REGISTRAR                                                                         |  |          |  |



## CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Allen, Richard

2. DATE AND HOUR OF DEATH

9/14/72

11:33 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATIONBaltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

BALTO

C. CITY OR TOWN

Baltimore

MIDDLE  
RIVER

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER

25 Oak Grove Drive

21220

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11/25/58

9. AGE (In years  
lost birthday)

14

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SCHOOL BOY

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES B. ALLEN

14. MOTHER'S MAIDEN NAME

ANNA BELLE VIANDS

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

4940 Eastern Avenue  
BCH-Records Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) LYMPHOBLASTIC LYMPHOSARCOMA

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (nearly medical examined)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that (I) (we) lost saw the deceased alive on \_\_\_\_\_ 19\_\_\_\_ and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M-FU Tsan M.D. PH.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

9/14/72

23C. PHYSICIAN'S  
NAME (Type)

M FU Tsan

M.D.

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

9/18/72

24C. NAME OF CEMETERY or CREMATORY

HOLLY HILL

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD

25A. DATE REC'D BY HEALTH DEPT.

SEP 18 1972

25B. NAME OF REGISTRAR

Arlene Wharton

25C. FUNERAL DIRECTOR

J.G. GONNELLY

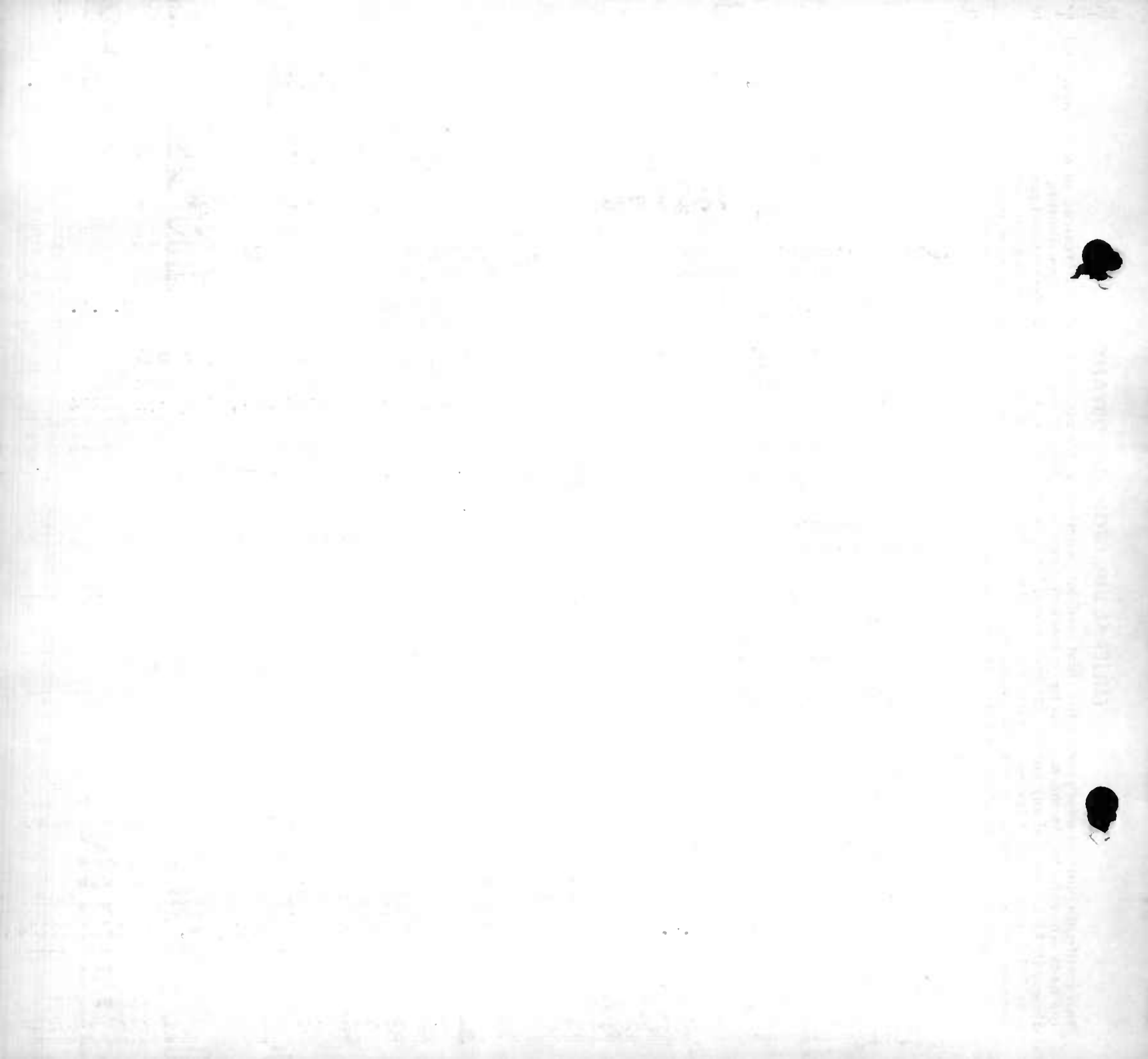
ADDRESS

300 MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



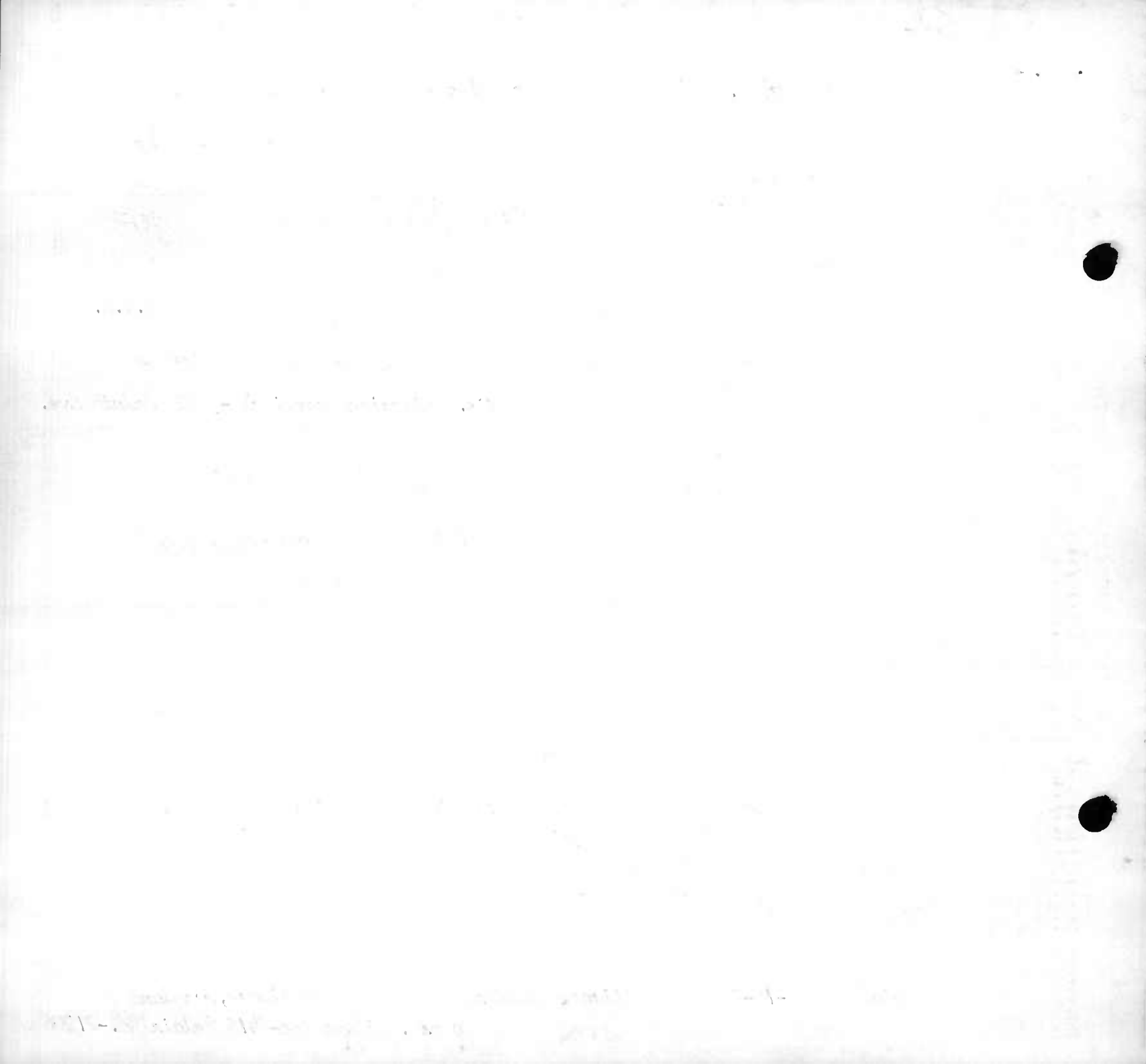




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

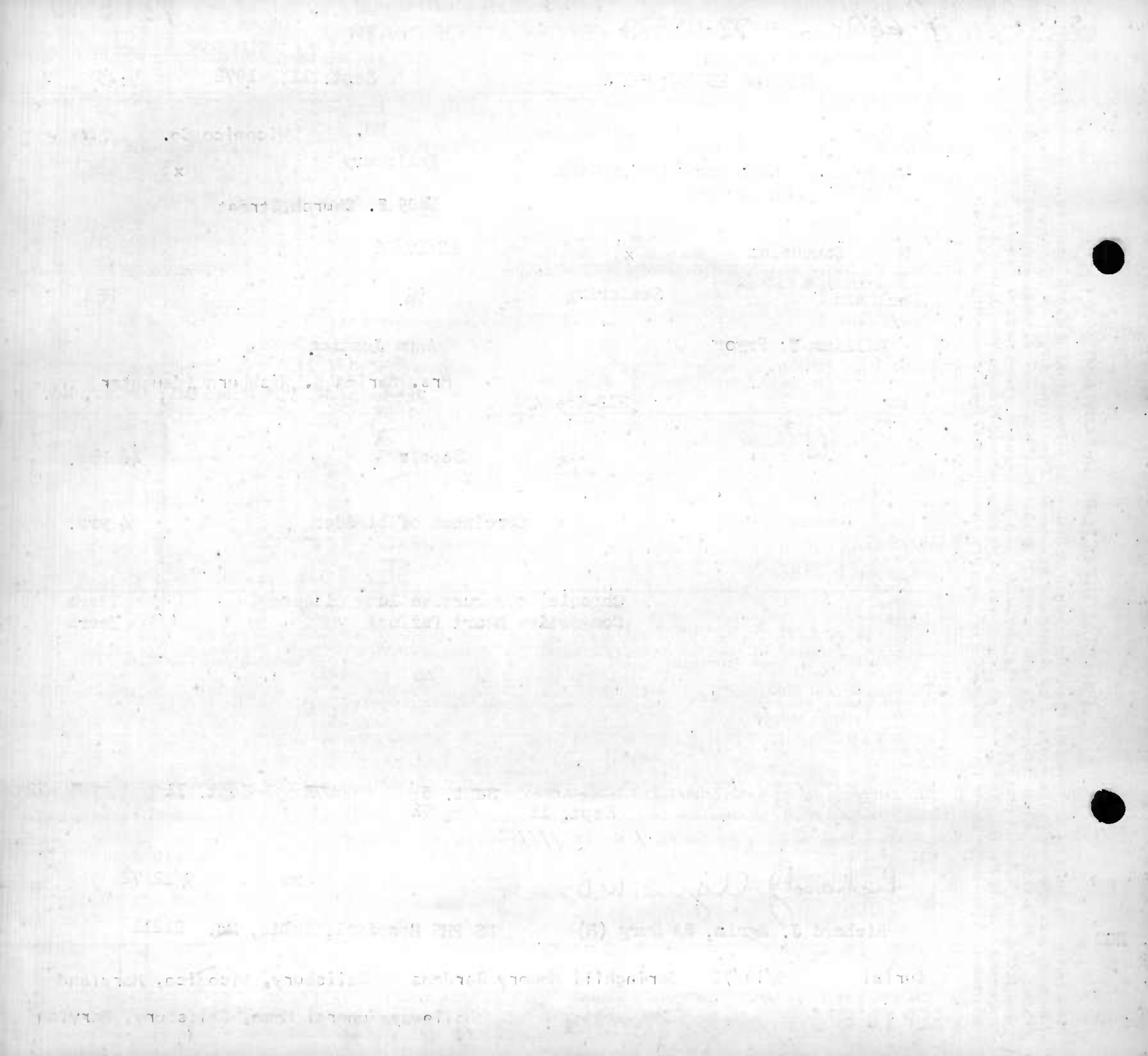
|                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             |                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                      |                  | REG. NO. 72 08878                                                                                                                                           |                                            |
| G-220 72 08878                                                                                                                                                                                                                                                                                                                                        |                  | STATE OF MARYLAND - BALTIMORE                                                                                                                               |                                            |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                             |                  | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                                            |
| 1. NAME OF DECEASED<br>(Type or Print) <u>LOUIS J. GOSEWISCH (Gosewisch)</u>                                                                                                                                                                                                                                                                          |                  | 9/13/72 840                                                                                                                                                 |                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>NORTH CHARLES GEN. HOSPITAL - N-CHARLES</u>                                                                                                                                                                                                                                                                |                  | A. STATE <u>MD</u><br>B. COUNTY <u>MARLATH ME.</u>                                                                                                          |                                            |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                                                                                    |                  | C. CITY OR TOWN <u>BALTIMORE</u>                                                                                                                            |                                            |
|                                                                                                                                                                                                                                                                                                                                                       |                  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                            |
|                                                                                                                                                                                                                                                                                                                                                       |                  | E. STREET AND NUMBER <u>5922 MARLATH AVE</u>                                                                                                                |                                            |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-5-11</u>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                           |                  | 10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>                                                                                                            | 9. AGE (In years lost birthday) <u>60</u>  |
|                                                                                                                                                                                                                                                                                                                                                       |                  | 11. BIRTHPLACE (State or foreign country) <u>PENN., U.S.A.</u>                                                                                              | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>LOUIS GOSEWISCH</u>                                                                                                                                                                                                                                                                                                              |                  | 14. MOTHER'S MAIDEN NAME <u>SOPHIE KALER</u>                                                                                                                |                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>                                                                                                                                                                                                                                    |                  | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                            |
|                                                                                                                                                                                                                                                                                                                                                       |                  | 17. INFORMANT ADDRESS <u>M's. Catherine Gosewisch - 5922 Marlath Ave.</u>                                                                                   |                                            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><u>518X I</u>                                                                                                                                   |                  | CAUSE OF DEATH                                                                                                                                              |                                            |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                        |                  | (A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                |                                            |
|                                                                                                                                                                                                                                                                                                                                                       |                  | (B) <u>RESPIRATORY INSUFFICIENCY</u><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                     |                                            |
|                                                                                                                                                                                                                                                                                                                                                       |                  | (C) <u>BROCHIECTASIS</u>                                                                                                                                    |                                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                            |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                            |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                             |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                 |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                            |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                             |                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                             |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                            |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> 19 <u>72</u> to <u>9-13</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                                            |
| 23A. SIGNATURE <u>John C. Miller M.D.</u>                                                                                                                                                                                                                                                                                                             |                  | 23B. DATE SIGNED                                                                                                                                            |                                            |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                          |                  | 23D. ADDRESS                                                                                                                                                |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                                |                  | 24B. DATE <u>9-16-72</u>                                                                                                                                    |                                            |
| 24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>                                                                                                                                                                                                                                                                                          |                  | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>                                                                                    |                                            |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 18 1972</u>                                                                                                                                                                                                                                                                                                    |                  | 25B. NAME OF REGISTRAR <u>Sidney H. ...</u>                                                                                                                 |                                            |
| 25C. FUNERAL DIRECTOR <u>John C. Miller Inc.</u>                                                                                                                                                                                                                                                                                                      |                  | ADDRESS <u>6415 Belair Rd. - 21206</u>                                                                                                                      |                                            |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | 72 08879                                                                                                  |  | 72 08879                                                                                                                                                    |  | 72 08879                                                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 1. NAME OF DECEASED<br>(Type or Print)                                                                    |  | 2. DATE AND HOUR OF DEATH                                                                                                                                   |  | STATE OF MARYLAND                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  | <b>CHARLES EDWARD PRYOR</b>                                                                               |  | <b>Sept. 11, 1972</b>                                                                                                                                       |  | <b>9:45 P M.</b>                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                     |  | A. STATE                                                                                                                                                    |  | B. COUNTY                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>US Public Health Service Hospital</b><br><b>3100 Wyman Parkway</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                      |  | <b>Md.</b>                                                                                                                                                  |  | <b>Wicomico Co.</b>                                                                   |  |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | 6. RACE<br><b>Caucasian</b>                                                                               |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12/27/86</b>                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Deckhand</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Seafaring</b>                                                     |  | 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b>                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                            |  |
| 13. FATHER'S NAME<br><b>William T. Pryor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Justice</b>                                                           |  | 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                    |  |                                                                                       |  |
| 16. SOCIAL SECURITY NO.<br><b>218-05-8471</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  | 17. INFORMANT<br><b>Mrs. Marion K. Washburn (daughter)</b><br><b>Records- US PHS Hospital, Balto, Md.</b> |  |                                                                                                                                                             |  | ADDRESS                                                                               |  |
| 18. <b>188X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Sepsis</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Carcinoma of bladder</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |  | CAUSE OF DEATH                                                                                            |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs.</b><br><b>4 yrs.</b>       |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Chronic obstructive lung disease</b><br><b>Congestive heart failure</b>                                                                                                                                                                                                                                                                                             |  |  |  | 19A. DATE OF OPERATION<br><b>0</b>                                                                        |  |                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  |
| 20A. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                      |  |                                                                                                                                                             |  | Years<br>Years                                                                        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |                                                                                                                                                             |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)           |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |                                                                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                            |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 5, 1972</b> to <b>Sept. 11, 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept. 11, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                    |  |  |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                       |  |
| 23A. SIGNATURE<br><b>Richard J. Agrin, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  | 23B. DATE SIGNED<br><b>9/12/72</b>                                                                        |  |                                                                                                                                                             |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Richard J. Agrin, SA Surg (R)</b>                  |  |
| 23D. ADDRESS<br><b>US PHS Hospital, Balto, Md. 21211</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                 |  |                                                                                                                                                             |  |                                                                                       |  |
| 24B. DATE<br><b>9/14/72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Springhill Memory Gardens</b>                                    |  |                                                                                                                                                             |  | 24D. LOCATION (City, town, or county) (State)<br><b>Salisbury, Wicomico, Maryland</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 25B. NAME OF REGISTRAR<br><b>Richard J. Agrin</b>                                                         |  |                                                                                                                                                             |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Holloway Funeral Home, Salisbury, Maryland</b>    |  |



1

B-623 72 08880 STATE OF MARYLAND - DEATH BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08880

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED A.<br>(Type or Print)<br><b>Patrica Burkett</b>                                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 9 12 72 M.                                            |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Union Memorial Hospital (D.O.A.)</b>                                                                                                                                                                                                |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>9 12 72<br>Hour: 10:20 p. M.                                                                                                |  |
| 6. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE<br><b>White</b>                                                                                                                                                  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                      |  |
| 9. DATE OF BIRTH<br><b>8/28/44</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (In years last birthday) <b>28</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                                                     |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                  |  | 12. CITIZEN OF<br><b>USA</b>                                                                                                                                             |  |
| 13. FATHER'S NAME<br><b>Burley Simmons</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 14. STREET AND NUMBER<br><b>3528 Old York Rd., Balto. Md.</b>                                                                                                            |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Clara Simmins</b>                                                                                                                                                                                                                                                                                                                                                              |  | 16. INFORMANT<br><b>James Goble 204 Marshall Dr</b>                                                                                                                      |  |
| 17. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                       |  | 18. ADDRESS<br><b>Forrest Hill, Md</b>                                                                                                                                   |  |
| 19. <b>E 965 X</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | CAUSE OF DEATH<br><b>Gunshot wounds of head</b>                                                                                                                          |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  | (C)                                                                                                                                                                      |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                            |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>UNK.</b>                                                                  |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Subject found in 6000 blk. of Amberwood Road</b>                                                                                                                                                                                                                                                                               |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>unk.</b>                                                                                                 |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                             |  | 22F. HOW DID INJURY OCCUR?<br><b>Subject shot by unknown assailant.</b>                                                                                                  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                          |  |
| ACTUAL SIGNATURE<br><b>Peter Lipkovic, M.D.</b>                                                                                                                                                                                                                                                                                                                                                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |  | DATE SIGNED<br><b>9/13/72</b>                                                                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>9/18/72</b>                                                                                                                                              |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Moreland Cemetery</b>                                                                                                                                                                                                                                                                                                                                                |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Co., Md.</b>                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Leonard J. Ruck Inc., Balto. Md 21214</b>                                                                                                   |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS                                                                                                                                                                  |  |

VS 151-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             |                                                                                                                                         | REG. NO. 72 08881                                                        |                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             |                                                                                                                                         | STATE OF MARYLAND-DCMH                                                   |                                                                                               |
| S-164<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 72 08881                                                                                                                                                    |                                                                                                                                         |                                                                          |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Sperling, Lee Sullivan</u>                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><u>9-13-72 4<sup>30</sup> PM</u>                                                                           |                                                                          |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>W. Va.</u><br>B. COUNTY <u>V45</u> |                                                                          |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Harbor View</u><br><u>90 1213 Light St</u><br><u>Baltimore - Md.</u>                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             | C. CITY OR TOWN<br><u>Elk Garden</u>                                                                                                    |                                                                          | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| E. STREET AND NUMBER<br><u>-</u>                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             | F. STREET AND NUMBER<br><u>-</u>                                                                                                        |                                                                          |                                                                                               |
| 5. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/16/1888</u>                                                                                                    | 9. AGE (In years last birthday)<br><u>83</u>                             | 10. Under 1 Yr. Months: Days: Hours: Min.                                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret. Coal Miner</u>                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><u>W. Va.</u>                                                                              |                                                                          |                                                                                               |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             | 13. FATHER'S NAME<br><u>Luther Sperling</u>                                                                                             |                                                                          |                                                                                               |
| 14. MOTHER'S MAIDEN NAME<br><u>Elizabeth Doman</u>                                                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>                   |                                                                          |                                                                                               |
| 16. SOCIAL SECURITY NO.<br><u>233-09-0360</u>                                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             | 17. INFORMANT<br><u>Burdock Funeral Home Kitzmiller, Md.</u>                                                                            |                                                                          |                                                                                               |
| 18. <u>185 X I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>(A) IMMEDIATE CAUSE <u>Cancer of Prostate</u></u><br><u>DUE TO, OR AS A CONSEQUENCE OF:</u><br><u>6</u><br><u>(B) _____</u><br><u>DUE TO, OR AS A CONSEQUENCE OF:</u><br><u>(C) _____</u> |                      |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Year</u>                                                                           |                                                                          |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Compensated CHF secondary to ASCVD</u>                                                                                                                                                                                                                                  |                      |                                                                                                                                                             | Years <u>_____</u>                                                                                                                      |                                                                          |                                                                                               |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                         | 20A. AUTOPSY? (Yes or No)                                                |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                              |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                            |                      | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                           |                                                                                                                                         | 21F. HOW DID INJURY OCCUR?                                               |                                                                                               |
| 22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>August 2</u> 19 <u>72</u> to <u>September 17</u> 19 <u>72</u> that <u>(H)</u> (we) last saw the deceased alive on <u>September 13</u> 19 <u>72</u> and that <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.                   |                      |                                                                                                                                                             |                                                                                                                                         |                                                                          |                                                                                               |
| 23A. SIGNATURE<br><u>Peter H Rheinwein, MD</u>                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                                         | 23B. DATE SIGNED<br><u>14 Sept 1972</u>                                  |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>PETER H RHEINWEIN, MD</u>                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             |                                                                                                                                         | 23D. ADDRESS<br><u>HARBOR VIEW CONVALESCENT CENTER</u>                   |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                            |                      | 24B. DATE<br><u>9/16/72</u>                                                                                                                                 |                                                                                                                                         | 24C. NAME of CEMETERY or CREMATORY<br><u>IOOF Cemetery</u>               |                                                                                               |
| 24D. LOCATION (City, town, or county) (State)<br><u>Elk Garden, W. Va.</u>                                                                                                                                                                                                                                                                                                                                           |                      | 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 18 1972</u>                                                                                                       |                                                                                                                                         |                                                                          |                                                                                               |
| 25B. NAME OF REGISTRAR<br><u>Sidney G. Johnson</u>                                                                                                                                                                                                                                                                                                                                                                   |                      | 25C. FUNERAL DIRECTOR<br><u>Leonard J. Buck Inc. Balto. Md.</u>                                                                                             |                                                                                                                                         |                                                                          |                                                                                               |



Case of Probate

Compounded CHM

1/10/1910

H. RHEV



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

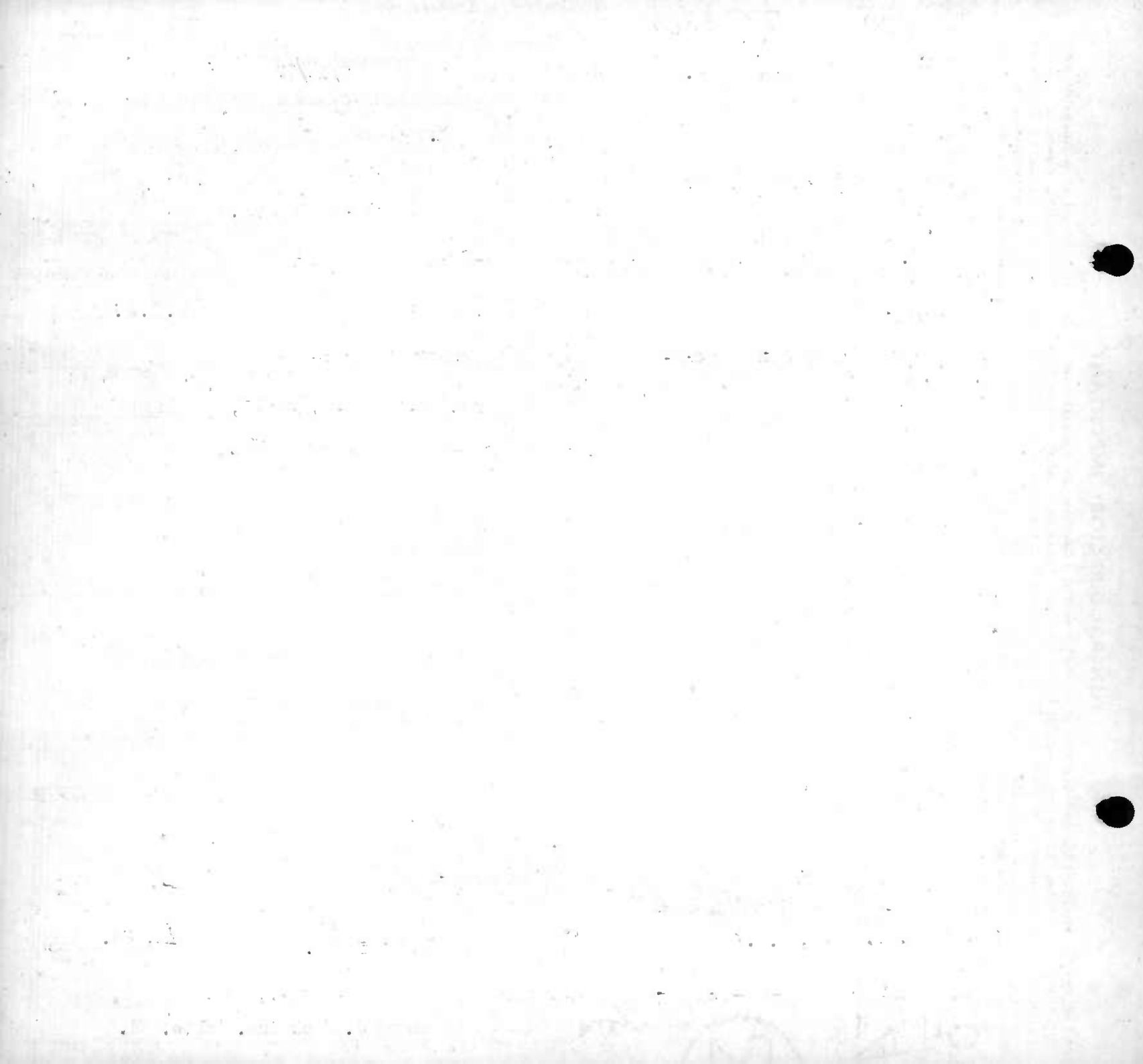
|                                                                                                                                                                                                                                                                                                              |  |                                                                                          |  |                                                                                                                                                             |  |                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| C-536                                                                                                                                                                                                                                                                                                        |  | 72 08882                                                                                 |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |  | 72 08882                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                    |  | 1. NAME OF DECEASED<br>(Type or Print)                                                   |  | 2. DATE AND HOUR OF DEATH                                                                                                                                   |  | REG. NO.                                                             |  |
|                                                                                                                                                                                                                                                                                                              |  | VERNON T. CANTER                                                                         |  | 09-14-72 10:45 A. M.                                                                                                                                        |  | STATE OF MARYLAND-DUMM                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                       |  |                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                       |  |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                 |  |                                                                                          |  | A. STATE B. COUNTY                                                                                                                                          |  |                                                                      |  |
| The Union Memorial Hospital                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | Maryland 903                                                                                                                                                |  |                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                       |  | 6. RACE                                                                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH                                                     |  |
| M                                                                                                                                                                                                                                                                                                            |  | W                                                                                        |  |                                                                                                                                                             |  | 05-23-02 70                                                          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                  |  |                                                                                          |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)                            |  |
| Ret. <del>2222222222</del>                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | Credit & Collection Balto. Gas & Elect.                                                                                                                     |  | Maryland                                                             |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                            |  |                                                                                          |  | 14. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                                                      |  |
| Joseph <del>Thomas</del> Canter                                                                                                                                                                                                                                                                              |  |                                                                                          |  | Barrie Jones                                                                                                                                                |  |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                     |  |                                                                                          |  | 16. SOCIAL SECURITY NO.                                                                                                                                     |  | 17. INFORMANT ADDRESS                                                |  |
| no <del>2222222222</del>                                                                                                                                                                                                                                                                                     |  |                                                                                          |  | B/65:212-05-5462                                                                                                                                            |  | Mrs. Beatrice Canter same                                            |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                           |  |                                                                                          |  | CAUSE OF DEATH                                                                                                                                              |  |                                                                      |  |
| 431.91                                                                                                                                                                                                                                                                                                       |  |                                                                                          |  | Cardiorespiratory Arrest                                                                                                                                    |  |                                                                      |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                               |  |                                                                                          |  | (B) Cerebrovascular Bleeding                                                                                                                                |  |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                             |  |                                                                                          |  | (C)                                                                                                                                                         |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 0                                                                                                                                                                                                                                                                                                            |  |                                                                                          |  | No                                                                                                                                                          |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR?                                                                                                                                |  | (If in Baltimore City, give exact location)                          |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                              |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                                                                                             |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from 08-23-72 1972 to 09-14-72 that (I) (we) last saw the deceased alive on 09-14-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                                                                                                             |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                               |  |                                                                                          |  | 23B. DATE SIGNED                                                                                                                                            |  |                                                                      |  |
| Dante Manyari, M.D.                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | 9-14-72                                                                                                                                                     |  |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                 |  |                                                                                          |  | 23D. ADDRESS                                                                                                                                                |  |                                                                      |  |
| DANTE MANYARI, M.D.                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | The Union Memorial Hospital.                                                                                                                                |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                     |  | 24B. DATE                                                                                |  | 24C. NAME of CEMETERY or CREMATORY                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                       |  | 9/18/72                                                                                  |  | Loudon Park Cem.                                                                                                                                            |  | Balto. Md.                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                              |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                                                                                       |  | ADDRESS                                                              |  |
| SEP 18 1972                                                                                                                                                                                                                                                                                                  |  | Sidney Johnston                                                                          |  | Leonard J. Ruck Inc. Balto. Md.                                                                                                                             |  |                                                                      |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             |                                                       | REG. NO. <u>72-18883</u>                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| S-400 72 18883                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                             |                                                       | STATE OF MARYLAND-DHMH                                                                        |
| BIRTH NO.                                                                                                                                                                                                                                                                                               |                      | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                                                       | 2. DATE AND HOUR OF DEATH                                                                     |
|                                                                                                                                                                                                                                                                                                         |                      | Rose F. Scheel                                                                                                                                              |                                                       | 9/11/72                                                                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                  |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                       |                                                       |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>00 5413 Mayview Avenue                                                                                                                                                                                                                                      |                      | A. STATE<br>Maryland                                                                                                                                        |                                                       |                                                                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                    |                      | C. CITY OR TOWN<br>Baltimore                                                                                                                                |                                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                         |                      | E. STREET AND NUMBER<br>5413 Mayview Ave.                                                                                                                   |                                                       |                                                                                               |
| 5. SEX<br>F.                                                                                                                                                                                                                                                                                            | 6. RACE<br>Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>9-28-90                           | 9. AGE (In years lost birthday)<br>81                                                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 11. BIRTHPLACE (State or foreign country)<br>Maryland | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                        |
| 13. FATHER'S NAME<br>Goswin <del>XXXXX</del> Beckman                                                                                                                                                                                                                                                    |                      | 14. MOTHER'S MAIDEN NAME<br>Augusta Crone                                                                                                                   |                                                       |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                          |                      | 16. SOCIAL SECURITY NO.                                                                                                                                     | 17. INFORMANT<br>Mrs. Julia Krokowski, Same           |                                                                                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>156.2 I<br>CARCINOMA of Ampulla of Vater                                                           |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year                                                                                                      |                                                       |                                                                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                          |                      | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF:                |                                                       |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                  |                      |                                                                                                                                                             |                                                       |                                                                                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                       | 20A. AUTOPSY? (Yes or No)                                                                     |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                 |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                               |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                       | 21F. HOW DID INJURY OCCUR?                                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from July 19 61 to 9-14 1972, that (I) (we) last saw the deceased alive on 9-8-1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |                                                                                                                                                             |                                                       |                                                                                               |
| 23A. SIGNATURE<br><i>W. K. Wong</i>                                                                                                                                                                                                                                                                     |                      | 23B. DATE SIGNED<br>9/14/72                                                                                                                                 |                                                       | 23C. PHYSICIAN'S NAME (Type)<br>W. K. Wong, M.D.                                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                      |                      | 24B. DATE<br>9-18-72                                                                                                                                        |                                                       | 24C. NAME of CEMETERY or CREMATORY<br>Holy Redeemer                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                          |                      | 25B. NAME OF REGISTRAR<br><i>Leonard J. Ruck</i>                                                                                                            |                                                       | 25C. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Balto., Md.                                     |
| 24D. LOCATION (City, town, or county)<br>Baltimore, Md.                                                                                                                                                                                                                                                 |                      | 24E. ADDRESS<br>6801 Belair Rd. Baltimore, Md. 21206                                                                                                        |                                                       |                                                                                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                       |                   |                                                                                                                                                                                                                                                                                                                              |                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>B-246</span> <span>72 08884</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 72 08884</span> </div>                                                                              |                   |                                                                                                                                                                                                                                                                                                                              |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BEICHLER MRS MARYC</b>                                                                                                                                                                                                                                                                                      |                   | 2. DATE AND HOUR OF DEATH<br><b>9/15/72 5:40 AM</b>                                                                                                                                                                                                                                                                          |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>CHURCH Home &amp; Hosp Balto Md.</b>                                                                                                                                    |                   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b><br>C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>8633 Quinter Ave. 21234</b> |                                                           |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <b>W.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                  | 8. DATE OF BIRTH <b>10-01-1909</b>                        |
| 9. AGE (In years last birthday) <b>62</b>                                                                                                                                                                                                                                                                                                             |                   | 10. UNDER 1 Yr. Months: Days: Hours: Min.                                                                                                                                                                                                                                                                                    | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>                                                                                                                                                                                                                                          |                   | 12. CITIZEN OF WHAT COUNTRY? <b>American</b>                                                                                                                                                                                                                                                                                 |                                                           |
| 13. FATHER'S NAME <b>THOMAS F. JOY</b>                                                                                                                                                                                                                                                                                                                |                   | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH DEBULUS</b>                                                                                                                                                                                                                                                                            |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>                                                                                                                                                                                                                                    |                   | 16. SOCIAL SECURITY NO. <b>218-70-9849</b>                                                                                                                                                                                                                                                                                   |                                                           |
| 17. INFORMANT <b>CHART-</b>                                                                                                                                                                                                                                                                                                                           |                   | ADDRESS                                                                                                                                                                                                                                                                                                                      |                                                           |
| 18. <b>4/10-91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. If means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cardiopulmonary arrest</b><br><b>Pulmonary Oedema, Shock</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Secondary to Myocardial Infarction</b><br>(C)                                                                                          |                                                           |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 Hr</b><br><b>1/2 Hr</b><br><b>24 Hr.</b>                                                                                                                                                                                                                                                     |                   |                                                                                                                                                                                                                                                                                                                              |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                |                   |                                                                                                                                                                                                                                                                                                                              |                                                           |
| 19A. DATE OF OPERATION <b>9/14/72</b>                                                                                                                                                                                                                                                                                                                 |                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                             |                                                           |
| 20A. AUTOPSY? (Yes or No) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                    |                   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                         |                                                           |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                               |                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                                                                                                                                                                                      |                                                           |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                              |                   | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                    |                                                           |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                |                   | 21F. HOW DID INJURY OCCUR                                                                                                                                                                                                                                                                                                    |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/14/1972</b> to <b>9/15/1972</b><br>that (I) (we) last saw the deceased alive on <b>9/15/1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                      |                   |                                                                                                                                                                                                                                                                                                                              |                                                           |
| 23A. SIGNATURE <b>M. Yousuf Siddiqui M.D.</b>                                                                                                                                                                                                                                                                                                         |                   | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                             |                                                           |
| 23C. PHYSICIAN'S NAME (Type) <b>M. YOUSUF SIDDIQUI M.D.</b>                                                                                                                                                                                                                                                                                           |                   | 23D. ADDRESS <b>CHURCH Home &amp; Hosp 100N. Broadway Balto MD 21231</b>                                                                                                                                                                                                                                                     |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                |                   | 24B. DATE <b>9/18/72</b>                                                                                                                                                                                                                                                                                                     |                                                           |
| 24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>                                                                                                                                                                                                                                                                                                    |                   | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                     |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                    |                   | 25B. NAME OF REGISTRAR <b>Leonard J Ruck Inc.</b>                                                                                                                                                                                                                                                                            |                                                           |
| 25C. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                         |                   | 25D. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                |                                                           |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

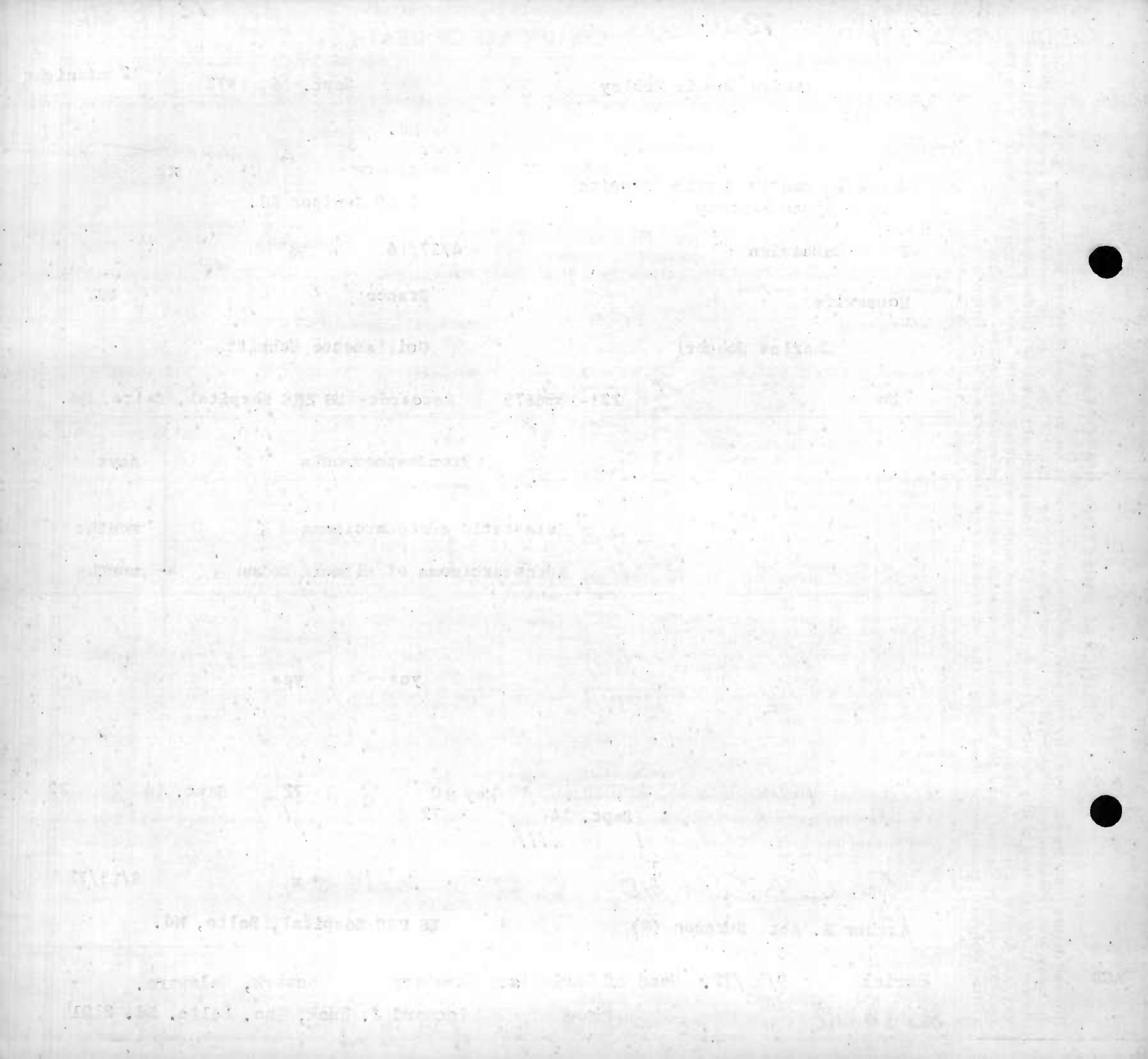
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                              | REG. NO. 72 08885                                                        |                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| L-516 72 08885                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                              | 72 08885                                                                 |                                                                                         |
| BIRTH NO.                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                              | STATE OF MARYLAND-DEME                                                   |                                                                                         |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LAMBRIGHT, August W. Sr.</b>                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>9-13-1972 11:00 A.M.</b>                                                                                                                                                                                                                                                                                     |                                                                          |                                                                                         |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>HAMILTON NURSING CENTER</b><br><b>90</b>                                                                                                                                                                       |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MD</b><br>B. COUNTY <b>2719 NORTHERN PARKWAY</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2719 NORTHERN PARKWAY</b> |                                                                          |                                                                                         |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                   | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-8-96</b>                                                                                                                                                                                                                                                                                                            | 9. AGE (In years lost birthday)<br><b>76 y.o.</b>                        | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>                                                                                                                                                                                                          |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>National Biscuit Co.</b>                                                                                                                                                                                                                                                                             |                                                                          | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                            |
| 13. FATHER'S NAME<br><b>John Lambright</b>                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Rosa Henley</b>                                                                                                                                                                                                                                                                                               |                                                                          |                                                                                         |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                      |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>212-017-1955</b>                                                                                                                                                                                                                                                                                               |                                                                          | 17. INFORMANT<br><b>Mrs. Lillian Lambright</b><br><b>Charles Sandkühler 405 Bingham</b> |
| 18. <b>73691</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)<br><b>Aspiration Pneumonia</b>                                                                        |                         |                                                                                                                                                             | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                          |                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days.</b>                          |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                          |                         |                                                                                                                                                             | (B) <b>Pharyngeal paralysis</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                           |                                                                          | <b>7 wks.</b>                                                                           |
|                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | (C) <b>Cerebral Vascular Accident</b>                                                                                                                                                                                                                                                                                                        |                                                                          | <b>7 wks.</b>                                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Chronic obstructive Pulmonary disease</b>                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                              |                                                                          | <b>yes.</b>                                                                             |
| 19A. DATE OF OPERATION<br><b>9-13-72</b>                                                                                                                                                                                                                                                                                |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                              | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |                                                                                         |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                          |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                         |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                               |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                              | 21F. HOW DID INJURY OCCUR?                                               |                                                                                         |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7-21-1972</b> to <b>9-13-1972</b> , that (I) (we) last saw the deceased alive on <b>9-12-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                              |                                                                          |                                                                                         |
| 23A. SIGNATURE<br><b>John C. Hyle</b><br>DEGREE                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                              | 23B. DATE SIGNED<br><b>9-13-72</b>                                       |                                                                                         |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JOHN C. HYLE</b>                                                                                                                                                                                                                                                                     |                         | 23D. ADDRESS<br><b>7527 Belair Rd Balto 21236 Md</b>                                                                                                        |                                                                                                                                                                                                                                                                                                                                              |                                                                          |                                                                                         |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                               |                         | 24B. DATE<br><b>9/16/72.</b>                                                                                                                                |                                                                                                                                                                                                                                                                                                                                              | 24C. NAME OF CEMETERY or CREMATORY<br><b>Jerusalem Lutheran Cemetery</b> |                                                                                         |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                              |                                                                          |                                                                                         |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                   |                         | 25B. NAME OF REGISTRAR<br><b>Sidney Johnson</b>                                                                                                             |                                                                                                                                                                                                                                                                                                                                              | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |                                                                                         |






This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                        |           |                                                                                         |                  |                                                                                       |                       |                                                                      |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------|--|
| 7-140                                                                                                                                                                                                                                                                                                                  |           | 72 08886                                                                                |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                       | REG. NO. 72 08886                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                              |           |                                                                                         |                  | STATE OF MARYLAND                                                                     |                       |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                 |           |                                                                                         |                  | 2. DATE AND HOUR OF DEATH                                                             |                       |                                                                      |  |
| Edith Sophie Zebley                                                                                                                                                                                                                                                                                                    |           |                                                                                         |                  | Sept. 14, 1972                                                                        |                       | 12 midnight M.                                                       |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                 |           |                                                                                         |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) |                       |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                              |           |                                                                                         |                  | A. STATE                                                                              |                       | B. COUNTY                                                            |  |
| US Public Health Service Hospital                                                                                                                                                                                                                                                                                      |           |                                                                                         |                  | Md.                                                                                   |                       | 1201                                                                 |  |
| 2X 3100 Wyman Parkway                                                                                                                                                                                                                                                                                                  |           |                                                                                         |                  | C. CITY OR TOWN                                                                       |                       | D. INSIDE CITY LIMITS?                                               |  |
|                                                                                                                                                                                                                                                                                                                        |           |                                                                                         |                  | Baltimore                                                                             |                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
|                                                                                                                                                                                                                                                                                                                        |           |                                                                                         |                  | E. STREET AND NUMBER                                                                  |                       |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                        |           |                                                                                         |                  | 3810 Juniper Rd.                                                                      |                       |                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                 | 6. RACE   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                                       | If Under 1 Yr. Months | If Under 24 Hrs. Days                                                |  |
| F                                                                                                                                                                                                                                                                                                                      | Caucasian | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      | 4/27/16          | 36                                                                                    |                       |                                                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                            |           | 10B. KIND OF BUSINESS OR INDUSTRY                                                       |                  | 11. BIRTHPLACE (State or foreign country)                                             |                       | 12. CITIZEN OF WHAT COUNTRY?                                         |  |
| Housewife                                                                                                                                                                                                                                                                                                              |           |                                                                                         |                  | France                                                                                |                       | USA                                                                  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                      |           |                                                                                         |                  | 14. MOTHER'S MAIDEN NAME                                                              |                       |                                                                      |  |
| Charles Schubel                                                                                                                                                                                                                                                                                                        |           |                                                                                         |                  | Guillamette Schmitt                                                                   |                       |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                               |           | 16. SOCIAL SECURITY NO.                                                                 |                  | 17. INFORMANT ADDRESS                                                                 |                       |                                                                      |  |
| No                                                                                                                                                                                                                                                                                                                     |           | 221-18-6679                                                                             |                  | Records- VS PHS Hospital, Balto, Md.                                                  |                       |                                                                      |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                     |           |                                                                                         |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                       |                                                                      |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                         |           |                                                                                         |                  | days                                                                                  |                       |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                           |           |                                                                                         |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |                       |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                      |           |                                                                                         |                  | (B) Metastatic adenocarcinoma                                                         |                       |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                              |           |                                                                                         |                  | DUE TO, OR AS A CONSEQUENCE OF:                                                       |                       |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                        |           |                                                                                         |                  | (C) Adenocarcinoma of sigmoid colon                                                   |                       |                                                                      |  |
| II                                                                                                                                                                                                                                                                                                                     |           |                                                                                         |                  |                                                                                       |                       |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                       |           |                                                                                         |                  |                                                                                       |                       |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                        |                  | 20A. AUTOPSY? (Yes or No)                                                             |                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 2                                                                                                                                                                                                                                                                                                                      |           |                                                                                         |                  | yes                                                                                   |                       | yes                                                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                  |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                       |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                        |           |                                                                                         |                  |                                                                                       |                       |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                          |           | 21E. INJURY OCCURRED                                                                    |                  | 21F. HOW DID INJURY OCCUR?                                                            |                       |                                                                      |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                            |           | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |                  |                                                                                       |                       |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from May 10 19 72 to Sept. 14 19 72, that (I) (we) last saw the deceased alive on Sept. 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |           |                                                                                         |                  |                                                                                       |                       |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                         |           |                                                                                         |                  | 23B. DATE SIGNED                                                                      |                       |                                                                      |  |
| Arthur B. Abt, M.D.                                                                                                                                                                                                                                                                                                    |           |                                                                                         |                  | 9/15/72                                                                               |                       |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                           |           |                                                                                         |                  | 23D. ADDRESS                                                                          |                       |                                                                      |  |
| Arthur B. Abt, Surgeon (R)                                                                                                                                                                                                                                                                                             |           |                                                                                         |                  | VS PHS Hospital, Balto, Md.                                                           |                       |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                               |           | 24B. DATE                                                                               |                  | 24C. NAME OF CEMETERY or CREMATORY                                                    |                       | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                                 |           | 9/18/72.                                                                                |                  | Head of Christiana Cemetery                                                           |                       | Newark, Delaware.                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                        |           | 25B. NAME OF REGISTRAR                                                                  |                  | 25C. FUNERAL DIRECTOR                                                                 |                       | ADDRESS                                                              |  |
| SEP 18 1972                                                                                                                                                                                                                                                                                                            |           | Sidney J. Horton                                                                        |                  | Leonard J. Ruck, Inc. Balto. Md. 21214                                                |                       |                                                                      |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

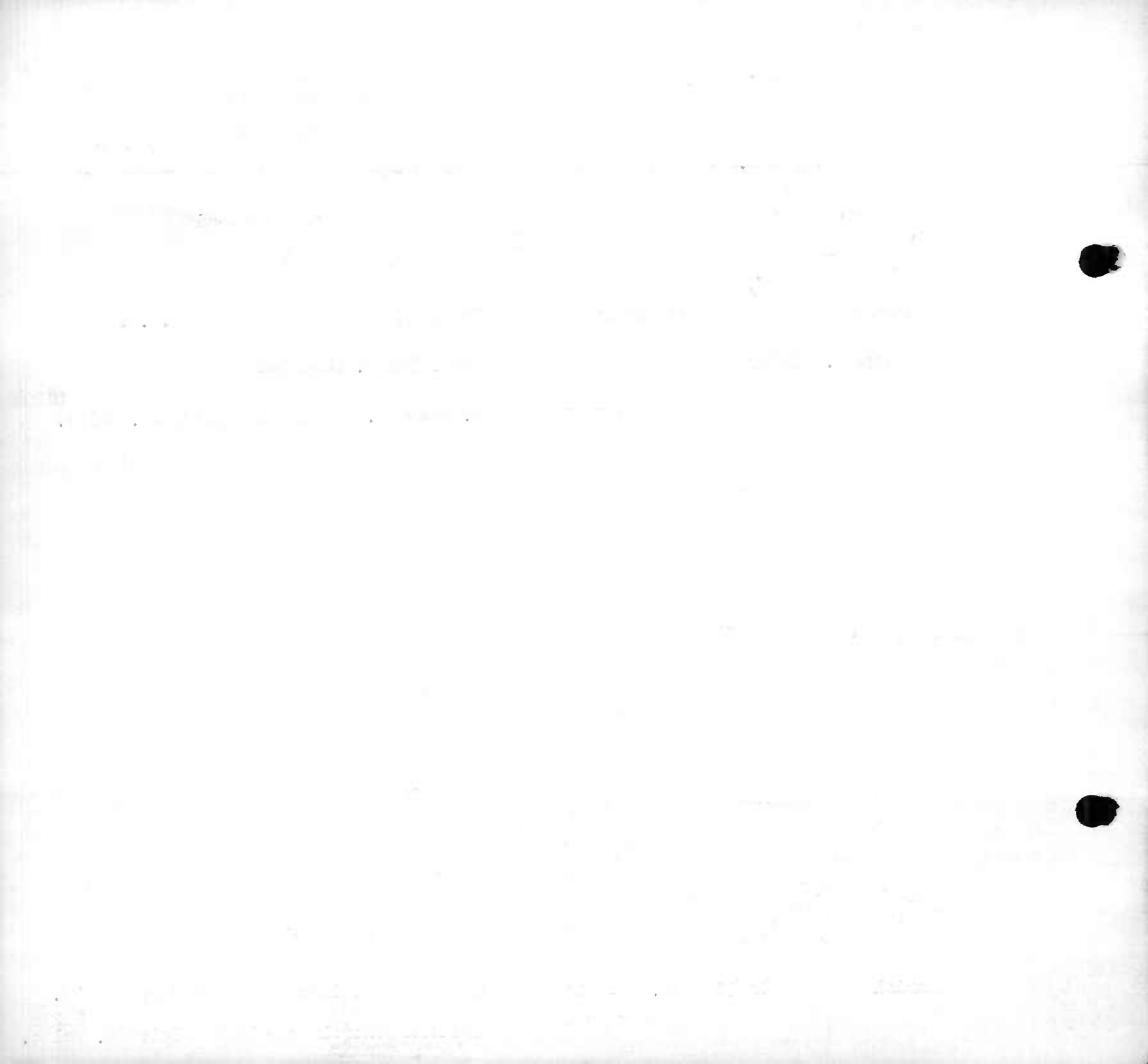
| H-620 72 08887                                                                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                        |                                       | 72 08887<br>REG. NO.                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             |  | STATE OF MARYLAND - DEPT.                                                                                                                                                               |                                       |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                               |                                       |                                                                                               |  |
| Albert Heurich                                                                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |  | 9/14/72 7:20 P. M.                                                                                                                                                                      |                                       |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                   |                                       |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>90 Harford Gardens Nursing Home                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                             |  | A. STATE B. COUNTY<br>Maryland Baltimore                                                                                                                                                |                                       |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                                            |                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br>2600 blk Greenmount Ave                                                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             |  |                                                                                                                                                                                         |                                       |                                                                                               |  |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                            | 6. RACE<br>Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>10/14/99                                                                                                                                                            | 9. AGE (In years last birthday)<br>72 | 10. UNDER 1 Yr. Months Days<br>Under 24 Hrs. Min.                                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Steel Com Bethlehem Steel                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                             |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                   |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                      |  |
| 13. FATHER'S NAME<br>Albert Heurich                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br>Louisa D. Wefelmeyer                                                                                                                                        |                                       |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br>219-07-9338                                                                                                                                                  |                                       | 17. INFORMANT ADDRESS<br>A Mrs. Frieda Sunderland<br>7805 Old Harford Rd Balto. Md.           |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>441.21<br><br>CAUSE OF DEATH<br>Ruptured abdominal aneurysm<br><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                      |                                                                                                                                                             |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 year +                                                                                                                                            |                                       |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             |  | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Generalized arteriosclerosis<br>Several years |                                       |                                                                                               |  |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                                                                               |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br>No                                                                                                                                                         |                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                     |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                |                                       |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                              |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                              |                                       |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 10 19 72 to Sept. 14 19 72, that (I) (we) last saw the deceased alive on Sept. 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.                                                                                                   |                      |                                                                                                                                                             |  |                                                                                                                                                                                         |                                       |                                                                                               |  |
| 23A. SIGNATURE<br><br>Loy M. Zimmerman MD.                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |  | 23B. DATE SIGNED<br>9/14/72                                                                                                                                                             |                                       | 23C. PHYSICIAN'S NAME (Type)<br>Loy M. Zimmerman MD.                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                        |                      | 24B. DATE<br>9/16/72                                                                                                                                        |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Western Cemetery                                                                                                                                  |                                       | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Maryland                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                                                                                                                                            |                      | 25B. NAME OF REGISTRAR<br>Ludwig H. Kohn                                                                                                                    |  | 25C. FUNERAL DIRECTOR ADDRESS<br>Leonard J. Luck Inc. Balto. Md.                                                                                                                        |                                       |                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |                                                                                                                    | X                                                                                            |                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| D-360                                                                                                                                                                                                                                                                                                                                                           |  | 72 08888                                                                                               |                                                                                                                    | CERTIFICATE OF DEATH                                                                         |                                                                                       |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                       |  | 72 08888                                                                                               |                                                                                                                    | REC. NO. 72 08888                                                                            |                                                                                       |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Elizabeth Dieter</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                        | 2. DATE AND HOUR OF DEATH<br><b>Sept. 14, 72 5:45 P.M.</b>                                                         |                                                                                              |                                                                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                              |                                                                                              |                                                                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Harford Gardens Nursing Home</b><br><b>4700 Harford Road</b><br><b>Baltimore, Maryland 21214</b>                                                                                                                                                                                                                     |  |                                                                                                        | A. STATE <b>Baltimore</b><br>B. COUNTY                                                                             |                                                                                              |                                                                                       |
| 5. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        | 6. RACE <b>White</b>                                                                                               |                                                                                              | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |
| 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                           |  |                                                                                                        | 9. DATE OF BIRTH <b>11/27/06</b>                                                                                   |                                                                                              | 10. AGE (in years last birthday) <b>65</b>                                            |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                         |                                                                                              | 13. FATHER'S NAME <b>George A. Dieter</b>                                             |
| 14. MOTHER'S MAIDEN NAME <b>Catherine M. Chetelat</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                        | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b> |                                                                                              |                                                                                       |
| 16. SOCIAL SECURITY NO. <b>213-50-8422M</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        | 17. INFORMANT <b>Mr. Frank P. Dieter</b> ADDRESS <b>418 Hillen Rd. Balto. 21204</b>                                |                                                                                              |                                                                                       |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of Stomach</b>                                                                                                                               |  |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 years</b>                                                     |                                                                                              |                                                                                       |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                              |  |                                                                                                        | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                |                                                                                              |                                                                                       |
| (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                |                                                                                              |                                                                                       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                             |  |                                                                                                        |                                                                                                                    |                                                                                              |                                                                                       |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                    | 20A. AUTOPSY (Yes or No) <b>No</b>                                                           |                                                                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |                                                                                       |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                       |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                    | 21F. HOW DID INJURY OCCUR?                                                                   |                                                                                       |
| 22. I certify that (I) (this hospital) attended the deceased from <b>6/9/72</b> 19 <b>72</b> to <b>Sept. 14</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Sept. 14</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |                                                                                                                    |                                                                                              |                                                                                       |
| 23A. SIGNATURE <b>Loy M. Zimmerman M.D.</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |                                                                                                                    | 23B. DATE SIGNED <b>Sept. 72</b>                                                             |                                                                                       |
| 23C. PHYSICIAN'S NAME (Type) <b>Loy M. Zimmerman M.D.</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |                                                                                                                    | 23D. ADDRESS <b>3202 Harford Rd. Baltimore, Md.</b>                                          |                                                                                       |
| 24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                           |  | 24B. DATE <b>9/18/72</b>                                                                               |                                                                                                                    | 24C. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>                              |                                                                                       |
| 24D. LOCATION <b>Fullerton</b>                                                                                                                                                                                                                                                                                                                                  |  | 24E. CITY, TOWN, OR COUNTY <b>Baltimore</b>                                                            |                                                                                                                    | 24F. STATE <b>Md.</b>                                                                        |                                                                                       |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                              |  | 25B. NAME OF REGISTRAR <b>Sidney H. ...</b>                                                            |                                                                                                                    | 25C. FUNERAL DIRECTOR <b>Lassan Funeral Home</b> ADDRESS <b>7401 Belair Rd. Balto. 21236</b> |                                                                                       |



| L-600                                                                                                                                                                                                                                                                                                                                                                                                                |  | 72 08889                                                                                                  |  | STATE OF MARYLAND                                                                                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT                                          |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                      |  | 72 08889                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | REG. NO.                                                                                                                                                                                    |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Mary Preisinger Lowery</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month <b>9</b> Day <b>13</b> Year <b>72</b><br>Estimated <input type="checkbox"/> Month <b>9</b> Day <b>13</b> Year <b>72</b> |  | 3. DATE PRONOUNCED DEAD<br>Month <b>9</b> Day <b>13</b> Year <b>72</b>    |  | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 1602 N. Caroline</b> |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>909</b> |  |
| 6. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 7. RACE<br><b>White</b>                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                 |  | C. CITY OR TOWN<br><b>Baltimore</b>                                       |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |  |                                                                                                                                        |  |
| 9. DATE OF BIRTH<br><b>Oct 27, 1898</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 10. AGE (In years last birthday)<br><b>73</b>                                                             |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md.</b>                                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |  | 13. FATHER'S NAME<br><b>John B. Preisinger</b>                                                                                                               |  |                                                                                                                                        |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodian</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Balto City Schools</b>                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br><b>Anna Mary Maier</b>                        |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                         |  | 17. SOCIAL SECURITY NO.                                                                                                                |  |
| 18. INFORMANT<br><b>Evelyn A. Menke</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  | 18. ADDRESS<br><b>6814 Harford Rd. 21234</b>                                                                                                                                                |  | 19. CAUSE OF DEATH<br><b>Arteriosclerotic cardiovascular disease</b>      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                 |  |                                                                                                                                        |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                       |  |                                                                                                           |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                      |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                         |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                                                             |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                               |  |                                                                                                           |  |                                                                                                                                                                                             |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| 20A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 21. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                                                                                       |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                 |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                    |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                            |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                                                  |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                           |  |                                                                                                                                                                                             |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                           |  | <b>Peter Lipkovic, M.D.</b>                                                                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                                             |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>            |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                                                          |  | DATE SIGNED<br><b>9/13/72</b>                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br><b>Sept 15, 72</b>                                                                           |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Dulaney Valley Memorial</b>                                                                                                                        |  | 24D. LOCATION (City, town, or county) (State)<br><b>Cockeysville, Md.</b> |  |                                                                                                                                                              |  |                                                                                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br><b>Adney Johnston</b>                                                           |  | 25C. FUNERAL DIRECTOR<br><b>Dippel Bro's Inc. 7110 Belair Road</b>                                                                                                                          |  |                                                                           |  |                                                                                                                                                              |  |                                                                                                                                        |  |

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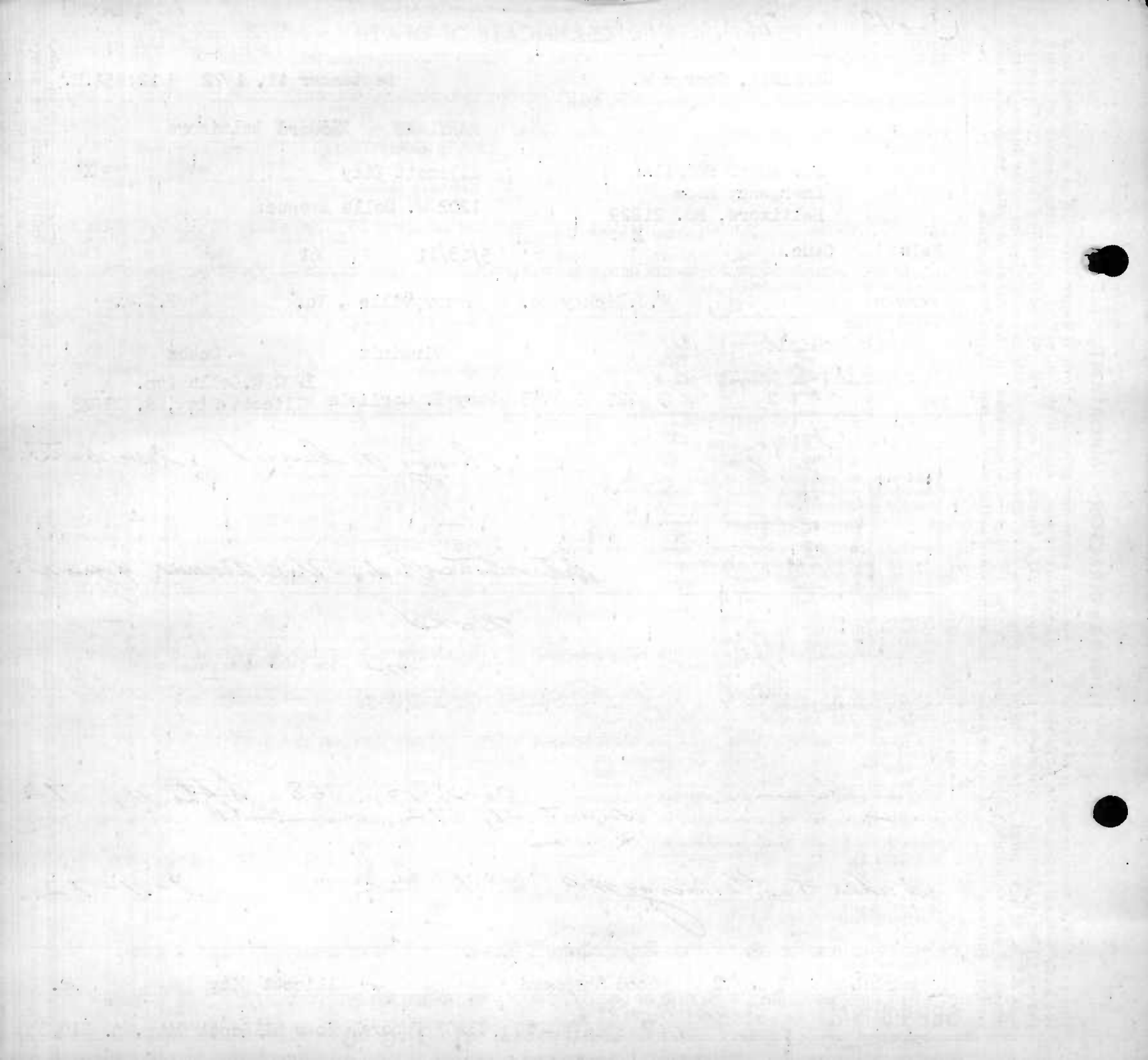
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

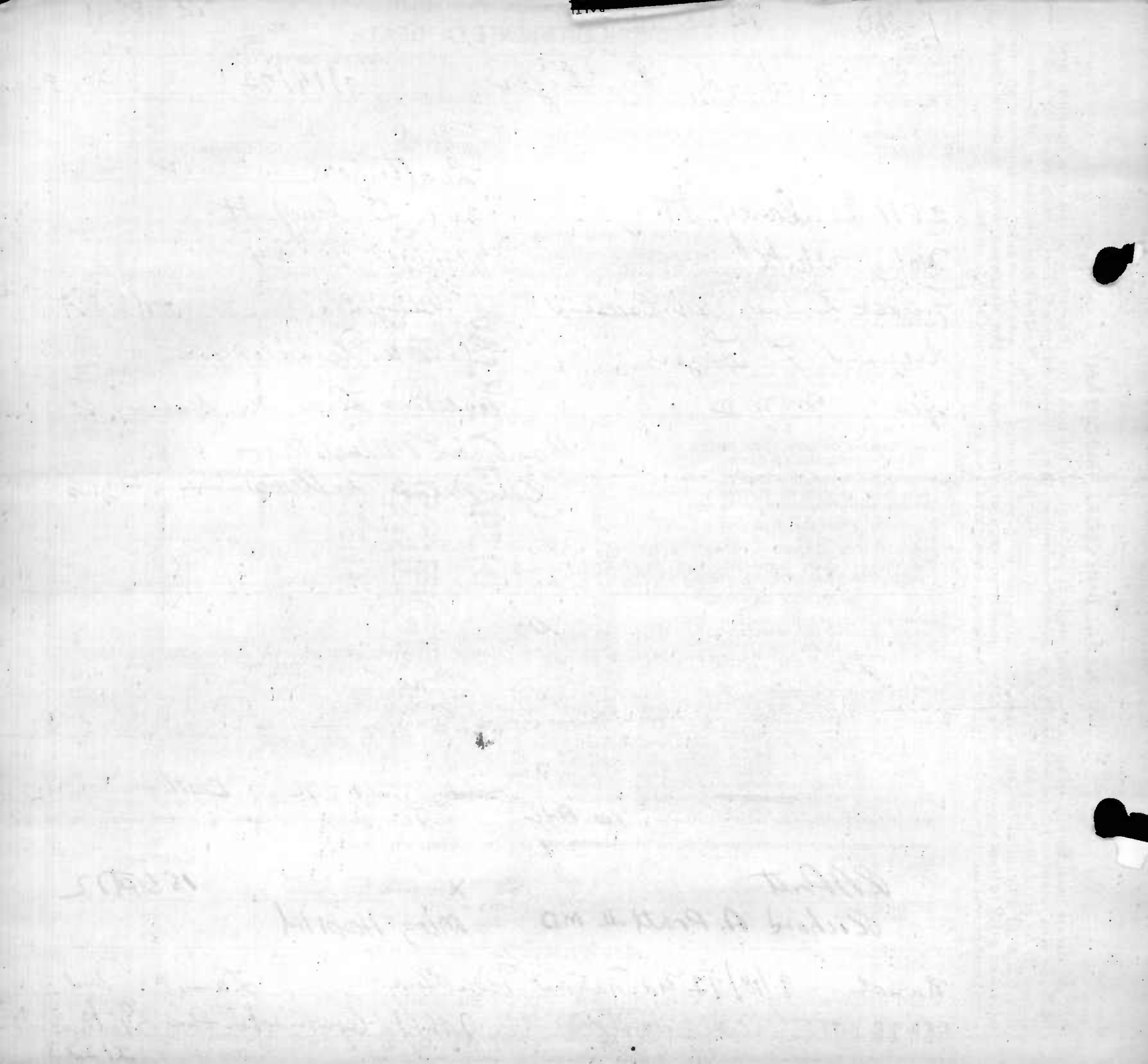
|                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                                                                        |                                                                      |                                                                                               |                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| C-642      72 08880                                                                                                                                                                                                                                                                                                      |                                                                                                           | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                       |                                                                      | 72 08880                                                                                      |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                |                                                                                                           | REG. NO.                                                                                                                                                                                               |                                                                      | STATE OF MARYLAND-DHMH                                                                        |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                   |                                                                                                           | 2. DATE AND HOUR OF DEATH                                                                                                                                                                              |                                                                      |                                                                                               |                                                           |
| CARLISLE, George W.                                                                                                                                                                                                                                                                                                      |                                                                                                           | September 11, 1972                                                                                                                                                                                     |                                                                      | 12:45A.M. M.                                                                                  |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                   |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                                                  |                                                                      |                                                                                               |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>ST. AGNES HOSPITAL<br>Emergency Room<br>Baltimore, Md. 21229                                                                                                                                                                                                                 |                                                                                                           | A. STATE<br>MARYLAND                                                                                                                                                                                   |                                                                      | B. COUNTY<br>Howard                                                                           |                                                           |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                     |                                                                                                           | C. CITY OR TOWN<br>Ellicott City                                                                                                                                                                       |                                                                      | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                           |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                           | E. STREET AND NUMBER<br>1202 W. Oella Avenue                                                                                                                                                           |                                                                      |                                                                                               |                                                           |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                           | 6. RACE<br>Cauc.                                                                                          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                            | 8. DATE OF BIRTH<br>5/18/11                                          | 9. AGE (In years lost birthday)<br>61                                                         | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>weaver                                                                                                                                                                                                                    |                                                                                                           | 10B. KIND OF BUSINESS OR INDUSTRY<br>W.J. Dickey Co.                                                                                                                                                   |                                                                      | 11. BIRTHPLACE (State or foreign country)<br>Berryville, Va.                                  |                                                           |
| 13. FATHER'S NAME<br>Frank Carlisle                                                                                                                                                                                                                                                                                      |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br>Virginia Gubbs                                                                                                                                                             |                                                                      | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                        |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes WW 2                                                                                                                                                                                                     |                                                                                                           | 16. SOCIAL SECURITY NO.<br>227 03 3753                                                                                                                                                                 |                                                                      | 17. INFORMANT<br>Mary T. Carlisle                                                             |                                                           |
|                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                                                                        |                                                                      | ADDRESS<br>1202 W. Oella Ave.<br>Ellicott City, Md. 21043                                     |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.      |                                                                                                           | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Pulmonary Occlusion</i><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>Arteriosclerotic Cardio-Vascular Disease. 4 years</i> |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Immediate</i>                              |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                                                                        |                                                                      |                                                                                               |                                                           |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          | 20A. AUTOPSY? (Yes or No)<br>No                                                                                                                                                                        | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                                               |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                               |                                                                      |                                                                                               |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                             |                                                                      |                                                                                               |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1968 to Sept. 11, 1972, that (I) (we) last saw the deceased alive on August 21, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                                                                        |                                                                      |                                                                                               |                                                           |
| 23A. SIGNATURE<br><i>William F. Yarnaway M.D.</i>                                                                                                                                                                                                                                                                        |                                                                                                           | 23B. DATE SIGNED<br>9-11-72                                                                                                                                                                            |                                                                      | 23C. PHYSICIAN'S NAME (Type)<br>William F. Yarnaway M.D.                                      |                                                           |
| 23D. ADDRESS                                                                                                                                                                                                                                                                                                             |                                                                                                           | 23E. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                         |                                                                      |                                                                                               |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>burial                                                                                                                                                                                                                                                                       |                                                                                                           | 24B. DATE<br>9/14/72                                                                                                                                                                                   |                                                                      | 24C. NAME OF CEMETERY or CREMATORY<br>Good Shepherd                                           |                                                           |
| 24D. LOCATION<br>Ellicott City                                                                                                                                                                                                                                                                                           |                                                                                                           | 24E. NAME OF REGISTRAR<br>Slack                                                                                                                                                                        |                                                                      |                                                                                               |                                                           |
| 24F. ADDRESS<br>Ellicott City, Md.                                                                                                                                                                                                                                                                                       |                                                                                                           | 24G. FUNERAL DIRECTOR<br>Slack Funeral Home Ellicott City, Md. 21043                                                                                                                                   |                                                                      |                                                                                               |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

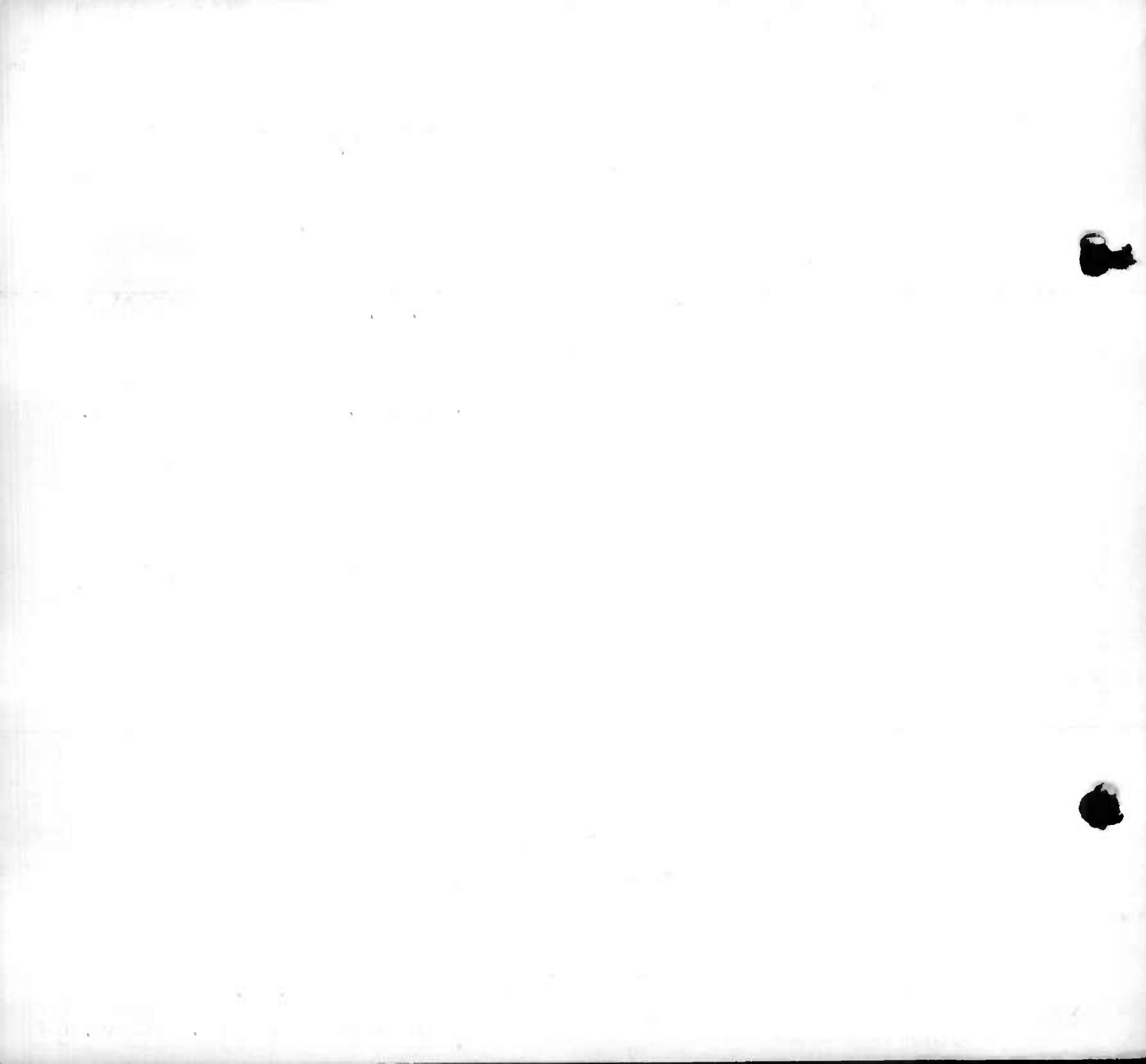
| Baltimore, Maryland, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                      | STATE OF MARYLAND - DHME                                                                      |                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Richard C. Lizer</i>                                                                                                                                                                                                                                                                                                                                 |                         | 2. DATE AND HOUR OF DEATH<br><i>9/14/72</i> <i>5:30 P.M.</i>                                                                                                |                                      | REG. NO. <i>72 08891</i>                                                                      |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                         |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                       |                                      | A. STATE <i>MD.</i> B. COUNTY <i>2005</i>                                                     |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>00</i>                                                                                                                                                                                                                                                                                                                                              |                         | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                         |                                      | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| E. STREET AND NUMBER<br><i>2611 Dulaney St.</i>                                                                                                                                                                                                                                                                                                                                                |                         | F. STREET AND NUMBER<br><i>2611 Dulaney St.</i>                                                                                                             |                                      |                                                                                               |                                                           |
| 5. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>4/12/1918</i> | 9. AGE in years (last birthday)<br><i>54</i>                                                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Quack Drive Path. Callahan</i>                                                                                                                                                                                                                                                                |                         | 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>                                                                                                |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                 |                                                           |
| 13. FATHER'S NAME<br><i>Richard L. Lizer</i>                                                                                                                                                                                                                                                                                                                                                   |                         | 14. MOTHER'S MAIDEN NAME<br><i>Clara A. Middlebrook</i>                                                                                                     |                                      |                                                                                               |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)<br><i>yes</i> <i>W.W.II</i>                                                                                                                                                                                                                                                            |                         | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                      | 17. INFORMANT<br><i>Madeline Lizer 2611 Dulaney St.</i>                                       |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><i>Progressive Melastetic</i>                                                                                                                                                                                                                                                                                                            |                         | CAUSE OF DEATH                                                                                                                                              |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 yrs</i>                                  |                                                           |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                   |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Ca. Primary Unknown</i>                                                                           |                                      |                                                                                               |                                                           |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                              |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                                      |                                                                                               |                                                           |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                      |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                                      |                                                                                               |                                                           |
| II                                                                                                                                                                                                                                                                                                                                                                                             |                         | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><i>NO</i>               |                                      |                                                                                               |                                                           |
| 19A. DATE OF OPERATION<br><i>0</i>                                                                                                                                                                                                                                                                                                                                                             |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                      | 20A. AUTOPSY? (Yes or No)<br><i>NO</i>                                                        |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                           |                         | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                     |                                      |                                                                                               |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                          |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                      |                                                                                               |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                      |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                      | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| 22. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>about July 1972</i> to <i>Death</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>16 AUG</i> 19 <i>72</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did not)</del> view the body after death. |                         |                                                                                                                                                             |                                      |                                                                                               |                                                           |
| 23A. SIGNATURE<br><i>R.A. Pratt</i>                                                                                                                                                                                                                                                                                                                                                            |                         | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                             |                                      | 23B. DATE SIGNED<br><i>15 Sept 72</i>                                                         |                                                           |
| 23C. PHYSICIAN'S NAME<br><i>Richard A. Pratt II MD</i>                                                                                                                                                                                                                                                                                                                                         |                         | 23D. ADDRESS<br><i>Morg Hospital</i>                                                                                                                        |                                      |                                                                                               |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                      |                         | 24B. DATE<br><i>9/18/72</i>                                                                                                                                 |                                      | 24C. NAME OF CEMETERY or CREMATORY<br><i>Ind. National Mem. Park</i>                          |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><i>Lanesh. Md.</i>                                                                                                                                                                                                                                                                                                                            |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 18 1972</i>                                                                                                       |                                      | 25B. NAME OF REGISTRAR<br><i>Sidney H. Wilson</i>                                             |                                                           |
| 25C. FUNERAL DIRECTOR<br><i>John J. Cowan &amp; Son Inc.</i>                                                                                                                                                                                                                                                                                                                                   |                         | 25D. ADDRESS<br><i>Gallatin St.</i>                                                                                                                         |                                      | 25E. ADDRESS<br><i>21223</i>                                                                  |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                                                                                                                                                                               |                                    |                                                                                                                               |                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>W-452</span> <span>72 08892</span> <span>72 08892</span> </div>                                                                                                                                                                                                                    |                  | <div style="display: flex; justify-content: space-between;"> <span>72 08892</span> <span>CERTIFICATE OF DEATH</span> <span>72 08892</span> </div>                                                                                                                                                             |                                    | <div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>STATE OF MARYLAND-DHMH</span> </div> |                                                                   |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Williams, Ray</i>                                                                                                                                                                                                                                                                                           |                  | 2. DATE AND HOUR OF DEATH<br><i>9-14-72 1:00 P.M.</i>                                                                                                                                                                                                                                                         |                                    |                                                                                                                               |                                                                   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Univ. of Md. Hosp.</i><br><i>38</i>                                                                                                                                     |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>AA</i><br>C. CITY OR TOWN <i>Glenn Burnie</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <i>9 Simac Rd.</i> |                                    |                                                                                                                               |                                                                   |
| 5. SEX <i>M</i>                                                                                                                                                                                                                                                                                                                                       | 6. RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                   | 8. DATE OF BIRTH<br><i>2-17-57</i> | 9. AGE (in years lost birthday)<br><i>15</i>                                                                                  | If Under 1 Yr. Months: Days: Hours: Min.<br>If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Student</i>                                                                                                                                                                                                                                         |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>-----                                                                                                                                                                                                                                                                    |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>Balto. Md.</i>                                                                |                                                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                                                                                                                                                                                                                            |                  | 13. FATHER'S NAME<br><i>Ray M. Williams, Sr.</i>                                                                                                                                                                                                                                                              |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Muriel Grogan</i>                                                                              |                                                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>                                                                                                                                                                                                                                 |                  | 16. SOCIAL SECURITY NO.<br>-----                                                                                                                                                                                                                                                                              |                                    | 17. INFORMANT ADDRESS<br><i>Mrs. Muriel D. Williams 1406 Marshall St. 21230</i>                                               |                                                                   |
| 18. <i>438.01</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><i>ischemic infarction, cerebral cortex, 6/4t.</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <i>anoxia</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <i>hypertensive encephalopathy of undet. origin</i>                                                             |                                    |                                                                                                                               |                                                                   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                |                  |                                                                                                                                                                                                                                                                                                               |                                    |                                                                                                                               |                                                                   |
| 19A. DATE OF OPERATION<br><i>9-12-72</i>                                                                                                                                                                                                                                                                                                              |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>48 Brain tumor</i>                                                                                                                                                                                                                                     |                                    | 20A. AUTOPSY? (Yes or No)<br><i>no</i>                                                                                        |                                                                   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                  |                  | (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                   |                                    |                                                                                                                               |                                                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                        |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                      |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                   |                                                                   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                             |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                        |                                    | 21F. HOW DID INJURY OCCUR?                                                                                                    |                                                                   |
| 22. I certify that (1) (this hospital) attended the deceased from <i>9/12</i> 19 <i>72</i> to <i>9/14</i> 19 <i>72</i> that (1) (we) last saw the deceased alive on <i>9/14/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.           |                  |                                                                                                                                                                                                                                                                                                               |                                    |                                                                                                                               |                                                                   |
| 23A. SIGNATURE<br><i>Francis J. Borges MD</i>                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                                                                                                                                                                               |                                    | 23B. DATE SIGNED<br><i>9/14/72</i>                                                                                            |                                                                   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>FRANCIS J. BORGES</i>                                                                                                                                                                                                                                                                                              |                  | 23D. ADDRESS<br>-----                                                                                                                                                                                                                                                                                         |                                    |                                                                                                                               |                                                                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                             |                  | 24B. DATE<br>-----                                                                                                                                                                                                                                                                                            |                                    | 24C. NAME of CEMETERY or CREMATORY<br><i>Cedar Hill Cemetery</i>                                                              |                                                                   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Md.</i>                                                                                                                                                                                                                                                                                    |                  | 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 18 1972</i>                                                                                                                                                                                                                                                         |                                    |                                                                                                                               |                                                                   |
| 25B. NAME OF REGISTRAR<br><i>Aldrey H. Horton</i>                                                                                                                                                                                                                                                                                                     |                  | 25C. FUNERAL DIRECTOR ADDRESS<br><i>McGuffy Funeral Home 130 E. Fort Ave. 21230</i>                                                                                                                                                                                                                           |                                    |                                                                                                                               |                                                                   |

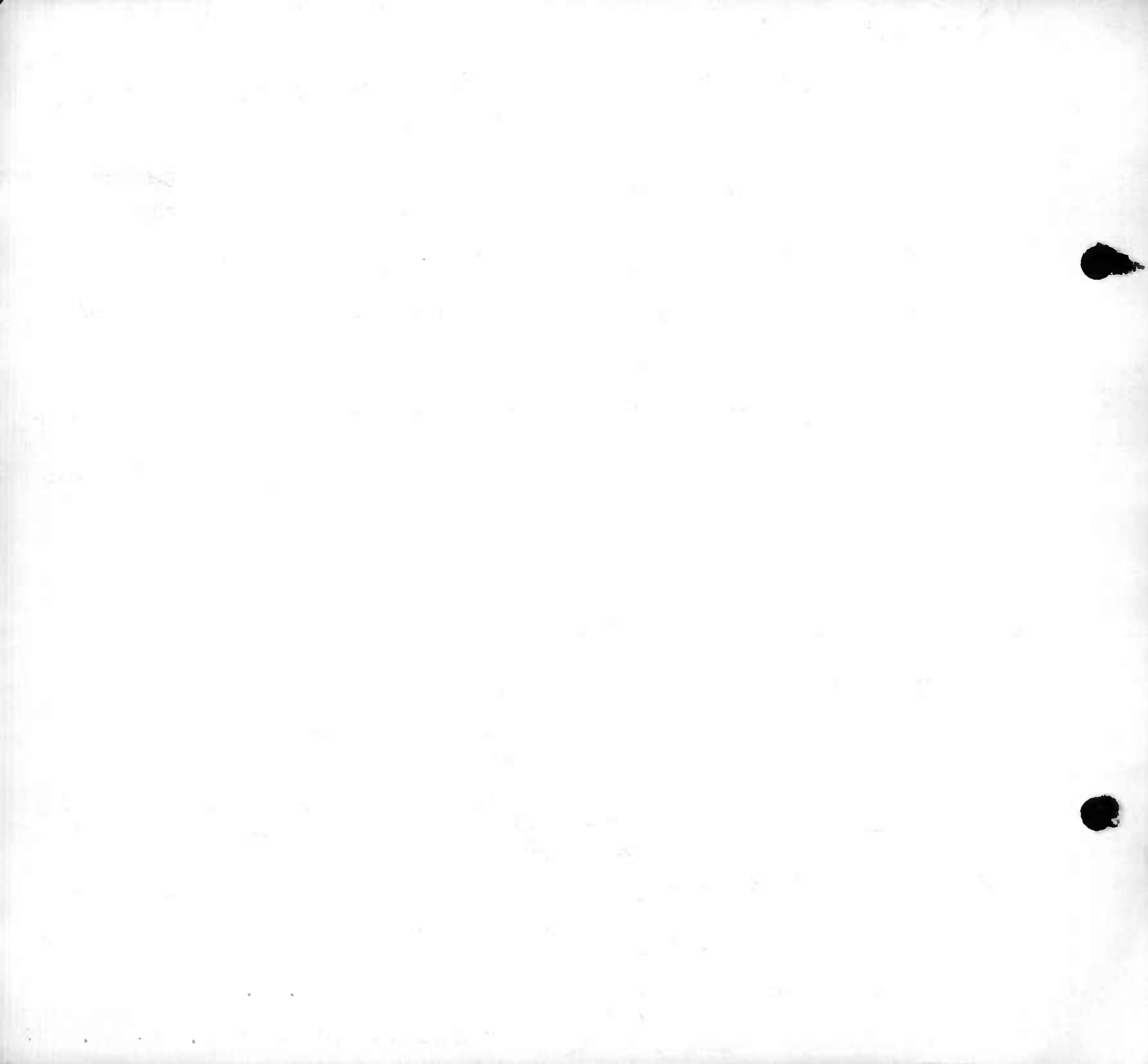




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |  |                                                                                                                                    |                                              |                                                                                               |                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------|
| BIRTH NO. <b>G-120</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 72 08893                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                   |                                              | 72 08893                                                                                      |                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |  | REG. NO.                                                                                                                           |                                              |                                                                                               |                              |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Scott H. Gibbs, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>9-13-72 4:30 P.M.</b>                                                                              |                                              |                                                                                               |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>2404</b> |                                              |                                                                                               |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>111 E. Barney Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             |  | C. CITY OR TOWN<br><b>City</b>                                                                                                     |                                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |  | E. STREET AND NUMBER<br><b>111 E. Barney Street</b>                                                                                |                                              |                                                                                               |                              |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6. RACE<br><b>W.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-27-1891</b>                                                                                               | 9. AGE (in years last birthday)<br><b>81</b> | 10. Under 1 Yr. Months Days                                                                   | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>American sugar</b>                                                                         |                                              | 11. BIRTHPLACE (State or foreign country)<br><b>W. Va.</b>                                    |                              |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             |  | 13. FATHER'S NAME<br><b>Fourt Gibbs</b>                                                                                            |                                              |                                                                                               |                              |
| 14. MOTHER'S MAIDEN NAME<br><b>Sarah Van Meter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                             |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes World War I</b> |                                              |                                                                                               |                              |
| 16. SOCIAL SECURITY NO.<br><b>212-09-6395</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             |  | 17. INFORMANT<br><b>MRS. Edna Coulford, daughter: son</b>                                                                          |                                              |                                                                                               |                              |
| 18. CAUSE OF DEATH<br><b>485X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Brochopneumonia</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                      |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>                                                                      |                                              |                                                                                               |                              |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>General arteriosclerosis</b>                                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |  | yrs.                                                                                                                               |                                              |                                                                                               |                              |
| 19A. DATE OF OPERATION<br><b>3-22-72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Rt. inguinal hernia</b>                                                                              |  | 20A. AUTOPSY? (Yes or No)<br><b>no</b>                                                                                             |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>—</b>                                                        |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><b>—</b>                                            |                                              |                                                                                               |                              |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?<br><b>—</b>                                                                                             |                                              |                                                                                               |                              |
| 22. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1971</b> to <b>Sept. 13, 1972</b> that (I) (we) last saw the deceased alive on <b>Sept. 13, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                            |                      |                                                                                                                                                             |  |                                                                                                                                    |                                              |                                                                                               |                              |
| 23A. SIGNATURE<br><b>C. C. Chiu, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |  | 23B. DATE SIGNED<br><b>9-13-72</b>                                                                                                 |                                              | 23C. PHYSICIAN'S NAME (Type)<br><b>C.C. CHIU, M.D.</b>                                        |                              |
| 23D. ADDRESS<br><b>1 E. Randall St. Balto. Md. 21230</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      |                                                                                                                                                             |  |                                                                                                                                    |                                              |                                                                                               |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 24B. DATE<br><b>9-16-72</b>                                                                                                                                 |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cemetery</b>                                                                  |                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                            |                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 25B. NAME OF REGISTRAR<br><b>Andrew Weston</b>                                                                                                              |  | 25C. FUNERAL DIRECTOR<br><b>McGully Funeral Home</b>                                                                               |                                              | ADDRESS<br><b>130 E. Fort Ave. 21230</b>                                                      |                              |





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72 08894

STATE OF MARYLAND - DEPARTMENT OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08894

BIRTH NO. D-200

|                                                                                                                                                                                                     |                                                                                                                                                             |                                                                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BARBARA Ann DUGAN</b>                                                                                                                                     |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> <b>September 12, 1972</b> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><b>4512 Wilmslow Road</b> |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>September 12, 1972 11:55 P.</b>                                                            |  |
| 6. SEX <b>Female</b>                                                                                                                                                                                |                                                                                                                                                             | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2714</b>         |  |
| 7. RACE <b>White</b>                                                                                                                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |
| 9. DATE OF BIRTH <b>Nov. 30, 1941</b>                                                                                                                                                               | 10. AGE (In years last birthday) <b>30</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                                        | E. STREET AND NUMBER <b>4512 Wilmslow Road</b>                                                                                                  |  |
| 11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>                                                                                                                                      | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                  | 13. FATHER'S NAME <b>E. A. Townsend</b>                                                                                                         |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Editor</b>                                                                                           | 14B. KIND OF BUSINESS OR INDUSTRY <b>Food Brokerage</b>                                                                                                     | 15. MOTHER'S MAIDEN NAME <b>Janet Wolfe</b>                                                                                                     |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>                                                                                  |                                                                                                                                                             | 17. SOCIAL SECURITY NO. <b>218-40-6891</b>                                                                                                      |  |
| 18. INFORMANT <b>E. A. Townsend, Parkton, Md.</b>                                                                                                                                                   |                                                                                                                                                             | ADDRESS <b>21120</b>                                                                                                                            |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                        |                                                                                                          |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------|
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 19. CAUSE OF DEATH<br><b>E 955X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Gunshot wound of head</b> |                                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                 |                                                                                                          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                    |                                                                                                          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                    |                                                                                                          |                                              |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                        |                                                                                                          |                                              |
| 20A. DATE OF OPERATION <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                        | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                         |                                              |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                        | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Bathroom</b> |                                              |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4512 Wilmslow Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                        | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>9-12-72 11:30 P.m.</b>                      |                                              |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                        | 22F. HOW DID INJURY OCCUR? <b>Self-inflicted</b>                                                         |                                              |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>9/13/72</b><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |                                                                                                                                                                                                                                                                        |                                                                                                          |                                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                        | 24B. DATE <b>Sept. 16, 1972</b>                                                                          |                                              |
| 24C. NAME OF CEMETERY or CREMATORY <b>Pine Grove Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                        | 24D. LOCATION (City, town, or county) (State) <b>Parkton, Md.</b>                                        |                                              |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                        | 25B. NAME OF REGISTRAR <b>Audrey Whitton</b>                                                             |                                              |
| 25C. FUNERAL DIRECTOR <b>James J. Hartenstein</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                        | ADDRESS <b>New Freedom, Pa.</b>                                                                          |                                              |

VS 151-REV. 1/1/68

N 854-720004890

X

X

Nov. 30, 1941

E. A. Townsend

U. S. A.

West Virginia

Just before

last

Expositor

Nov. 30, 1941 E. A. Townsend, Parkton, Md.

No. —

THIS IS A COPY OF THE

ORIGINAL

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11:30 A

11:30 A

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RECEIVED

Parkton, Md.

Sept. 14, 1942

1941

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                       |                                                                                       |                                          |                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------------|--|
| C-500                                                                                                                                                                                                                                                                                                                                        |                         | 72 08895                                                                                                                                                    |                                       | BALTIMORE CITY HEALTH DEPT.                                                           |                                          | 72 08895                                                                           |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                       | REG. NO.                                                                              |                                          |                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Theodore Cohen</i>                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                       | 2. DATE AND HOUR OF DEATH<br><i>September 12/72 4:15 P.M.</i>                         |                                          |                                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                          |                                                                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Sinai Hospital</i>                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                       | A. STATE<br><i>Maryland</i>                                                           |                                          | B. COUNTY<br><i>Baltimore</i>                                                      |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                       | C. CITY OR TOWN<br><i>Baltimore</i>                                                   |                                          | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><i>3106 Bonnie Road</i>                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                       |                                                                                       |                                          |                                                                                    |  |
| 5. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                        | 6. RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>12/25/1894</i> | 9. AGE (In years lost birthday)<br><i>77</i>                                          | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min.                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Executive</i>                                                                                                                                                                                                                              |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>mgm news casting</i>                                                                                                |                                       | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore</i>                         |                                          | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                         |  |
| 13. FATHER'S NAME<br><i>Isaac Cohn</i>                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                       | 14. MOTHER'S MAIDEN NAME<br><i>Sonia Janofsky</i>                                     |                                          |                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                                        |                         | 16. SOCIAL SECURITY NO.<br><i>215-03-2321</i>                                                                                                               |                                       | 17. INFORMANT<br><i>IRVING COHEN - Velvet Valley Way</i>                              |                                          |                                                                                    |  |
| 18. <i>436.9 I</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                                          |                                                                                    |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                |                         |                                                                                                                                                             |                                       | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>cardiac arrest</i>       |                                          | <i>minutes</i>                                                                     |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                       | (B) <i>(possible) cerebrovascular accident</i><br>DUE TO, OR AS A CONSEQUENCE OF:     |                                          |                                                                                    |  |
| (C) _____                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                       |                                                                                       |                                          |                                                                                    |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                       |                                                                                       |                                          |                                                                                    |  |
| 19A. DATE OF OPERATION<br><i>0</i>                                                                                                                                                                                                                                                                                                           |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                       | 20A. AUTOPSY (Yes or No)<br><i>No</i>                                                 |                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                        |                         | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)                                                                    |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                          |                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                    |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                       | 21F. HOW DID INJURY OCCUR?                                                            |                                          |                                                                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 8, 1972</i> to <i>Sept. 12, 1972</i> , that (I) (we) lost saw the deceased alive on <i>Sept. 11, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                       |                                                                                       |                                          |                                                                                    |  |
| 23A. SIGNATURE<br><i>Philip R. Reid for Leonard Lister, M.D.</i>                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                       |                                                                                       |                                          | 23B. DATE SIGNED<br><i>Sept. 13, 1972</i>                                          |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                 |                         | DEGREE<br><i>M.D.</i>                                                                                                                                       |                                       | ADDRESS<br><i>7111 Park Heights Ave, Balt.</i>                                        |                                          |                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                    |                         | 24B. DATE<br><i>Sept 14/72</i>                                                                                                                              |                                       | 24C. NAME OF CEMETERY or CREMATORY<br><i>Beth El Haim</i>                             |                                          | 24D. LOCATION (City, town, or county) (State)<br><i>Reisterstown, Md</i>           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 18 1972</i>                                                                                                                                                                                                                                                                                        |                         | 25B. NAME OF REGISTRAR<br><i>Sidney Johnston</i>                                                                                                            |                                       | 25C. FUNERAL DIRECTOR<br><i>Sol Leiman &amp; Sons</i>                                 |                                          | ADDRESS<br><i>6010 East. Road</i>                                                  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                 |                        |                                                                                                                                                                                    |                               |                                                                                                      |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                                                |                        | 72 08896                                                                                                                                                                           |                               | Registered No. <span style="float: right;">12 00000</span>                                           |                                                           |
| BIRTH NO. <span style="float: right;">H-155</span>                                                                                                                                                                                                                                                                                                                              |                        | M.E. CASE NO. <span style="float: right;">F.</span>                                                                                                                                |                               | STATE OF MARYLAND-DHMH                                                                               |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                          |                        | DORA HOFFMAN                                                                                                                                                                       |                               | 2. DATE AND HOUR OF DEATH<br>September 12, 1972 8:20 A.M.                                            |                                                           |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND                                                                                                                                                                                                                                                                                                                                        |                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY BALTO 5300                                                 |                               | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore                 |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL                                                                                                                                                                                                                                                                                          |                        | (If not in hospital or institution, give street address or location)                                                                                                               |                               | D. STREET ADDRESS (If rural, give location)<br>4206 Bedford Road                                     |                                                           |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br>Cauc. White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br>Widow                                                                                                                    | 8. DATE OF BIRTH<br>4-10-1881 | 9. AGE (In years lost birthday)<br>91                                                                | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                                                                                        |                        | 10B. KIND OF BUSINESS OR INDUSTRY<br>At Home                                                                                                                                       |                               | 11. BIRTHPLACE (State or foreign country)<br>Poland                                                  |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                             |                        | 13. FATHER'S NAME<br>? Fisher                                                                                                                                                      |                               | 14. MOTHER'S MAIDEN NAME<br>Unknown                                                                  |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                  |                        | 16. SOCIAL SECURITY NO.<br>214-50-3334                                                                                                                                             |                               | 17. INFORMANT ADDRESS<br>Mr. Irvin Hoffman 4206 Bedford Road 21208                                   |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                              |                        | CAUSE OF DEATH<br>(A) DUE TO Pulm. Embolism or an abscess<br>(B) DUE TO Fr. of femur (Rt) infected wound.<br>(C) Generalized osteoporosis<br>generalized arteriosclerosis<br>ASCRB |                               | INTERVAL BETWEEN ONSET AND DEATH<br>48 days<br>18 days<br>years                                      |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                            |                        |                                                                                                                                                                                    |                               |                                                                                                      |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                   |                               | 20A. AUTOPSY? (Yes or No)                                                                            |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                           |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                           |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                             |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                       |                        | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                          |                               | 21F. HOW DID INJURY OCCUR?                                                                           |                                                           |
| 22. I certify that <del>XX</del> (this hospital) attended the deceased from September 23 1970 to September 12 1972, that <del>XX</del> (we) last saw the deceased alive on September 12 1972 and that in <del>XXX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>N</del> (We) (did) <del>XXXXX</del> view the body after death. |                        |                                                                                                                                                                                    |                               |                                                                                                      |                                                           |
| 23A. SIGNATURE<br>Kamal M. Jain, on approval of medical examiner Dr. Cornblow                                                                                                                                                                                                                                                                                                   |                        | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                               |                               | 23B. DATE SIGNED<br>9.12.72                                                                          |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br>Kamal M. Jain                                                                                                                                                                                                                                                                                                                                   |                        | 23D. ADDRESS<br>M.D. Levindale Hebrew Geriatric Center & Hosp.                                                                                                                     |                               |                                                                                                      |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                              |                        | 24B. DATE<br>9/13/72                                                                                                                                                               |                               | 24C. NAME OF CEMETERY or CREMATORY<br>Ohr Knesseth Israel Anshe Sfard German Hill Rd. Baltimore, Md. |                                                           |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                                                   |                        | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                     |                               |                                                                                                      |                                                           |
| 25B. NAME OF REGISTRAR<br>Sidney [unclear]                                                                                                                                                                                                                                                                                                                                      |                        | 25C. FUNERAL DIRECTOR ADDRESS<br>Sol Levinson & Bros. 6010 Reisterstown Road                                                                                                       |                               |                                                                                                      |                                                           |

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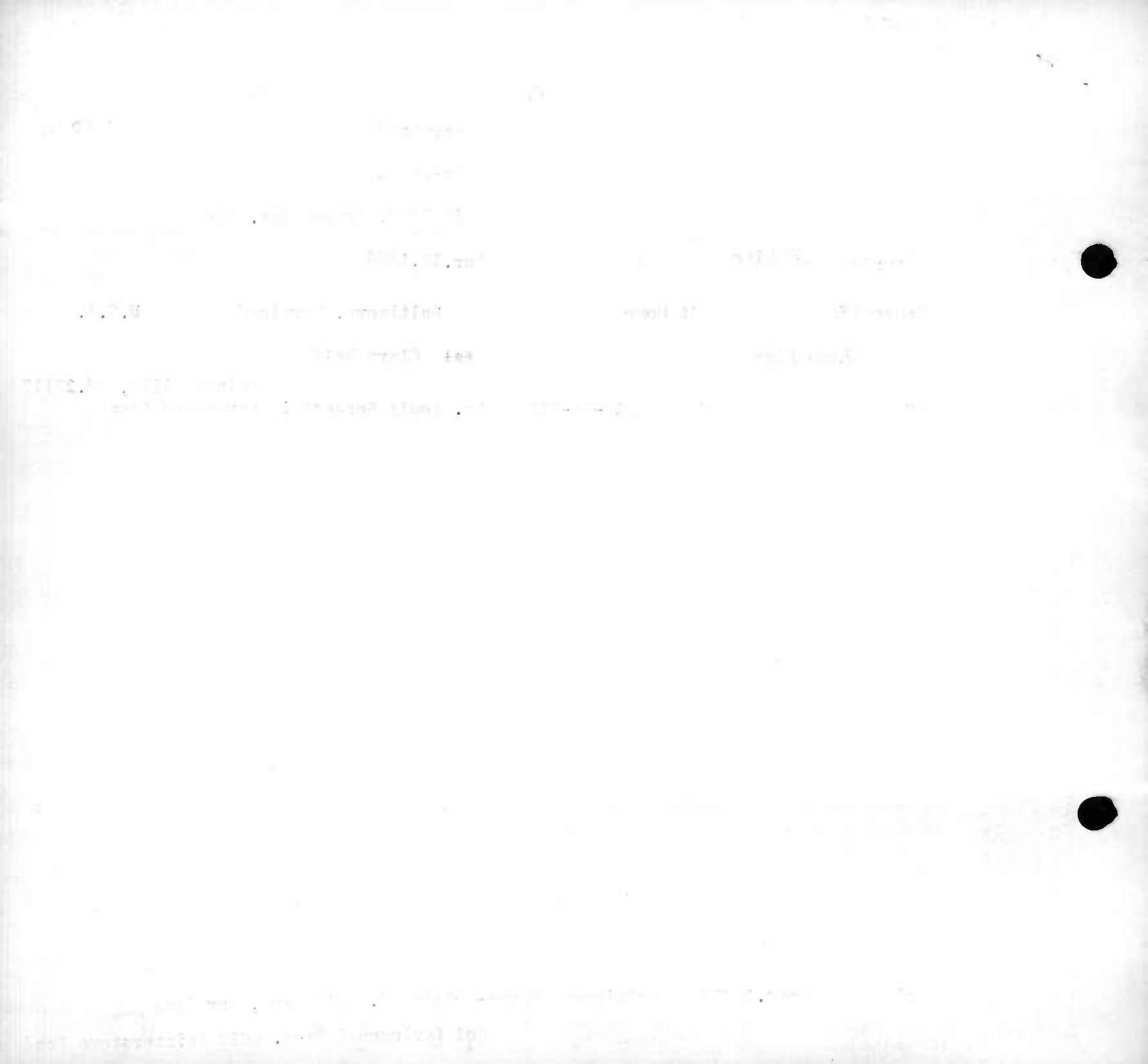
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                                                                                                                 |                                   | REG. NO. 72 08897                                                                     |                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------|
| BIRTH NO. R-252                                                                                                                                                                                                                                                                                            |                  | 72 08897                                                                                                                                                                                                                                        |                                   | CERTIFICATE OF DEATH                                                                  |                                                                |
| 1. NAME OF DECEASED<br>(Type or Print) ROSENSTEIN, BLANCHE K.                                                                                                                                                                                                                                              |                  | 2. DATE AND HOUR OF DEATH<br>9/13/72 1:00 P. M.                                                                                                                                                                                                 |                                   |                                                                                       |                                                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>Sinai Hosp. of Baltimore, Inc.                                                                                                                                                                                                                   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |                                                                                       |                                                                |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Sinai Hosp. of Baltimore, Inc.                                                                                                                                                                |                  | E. STREET AND NUMBER<br>11 Slade Avenue Apt. 808                                                                                                                                                                                                |                                   |                                                                                       |                                                                |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                           | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                     | 8. DATE OF BIRTH<br>Mar. 12, 1894 | 9. AGE (In years last birthday)<br>78                                                 | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>At Home                                                                                                                                                                                                    |                                   | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                      |                                                                |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                     |                  | 13. FATHER'S NAME<br>Jacob King                                                                                                                                                                                                                 |                                   | 14. MOTHER'S MAIDEN NAME<br>Clara Wolf                                                |                                                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                             |                  | 16. SOCIAL SECURITY NO.<br>216-46-2139                                                                                                                                                                                                          |                                   | 17. INFORMANT<br>Owings Mills, Md. 21117<br>Mr. Louis Rosenstein Caveswood Lane       |                                                                |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>592X1                                                                                                  |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Uremia<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>Chronic Renal Failure<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>Renal calculus                                        |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks<br>± 9 yrs.<br>± 9 yrs.       |                                                                |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>II<br>Congestive Heart Failure & Hypertension                                                                                                                      |                  | 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                     |                                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |                                                                |
| 20A. AUTOPSY? (Yes or No)<br>No                                                                                                                                                                                                                                                                            |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                            |                                   | 20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                          |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                        |                                   | 21C. WHERE DID INJURY OCCUR?                                                          |                                                                |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                               |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                       |                                   | 21F. HOW DID INJURY OCCUR?                                                            |                                                                |
| 22. I certify that (I) (this hospital) attended the deceased from 8/3 19 72 to 9/13 19 72 that (I) (we) last saw the deceased alive on 9/13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                                                                                                                 |                                   |                                                                                       |                                                                |
| 23A. SIGNATURE<br>Veneranda C. Gerapini m.d.                                                                                                                                                                                                                                                               |                  | 23B. DATE SIGNED<br>9/13/72                                                                                                                                                                                                                     |                                   | 23C. PHYSICIAN'S NAME (Type)<br>Veneranda C. Gerapini's                               |                                                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                         |                  | 24B. DATE<br>Sept. 15/72                                                                                                                                                                                                                        |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br>Baltimore Hebrew-Belair Rd. Baltimore, Maryland |                                                                |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                             |                  | 25B. NAME OF REGISTRAR<br>Sol Devinson                                                                                                                                                                                                          |                                   | 25C. FUNERAL DIRECTOR<br>& Bros. 6010 Reisterstown Road                               |                                                                |

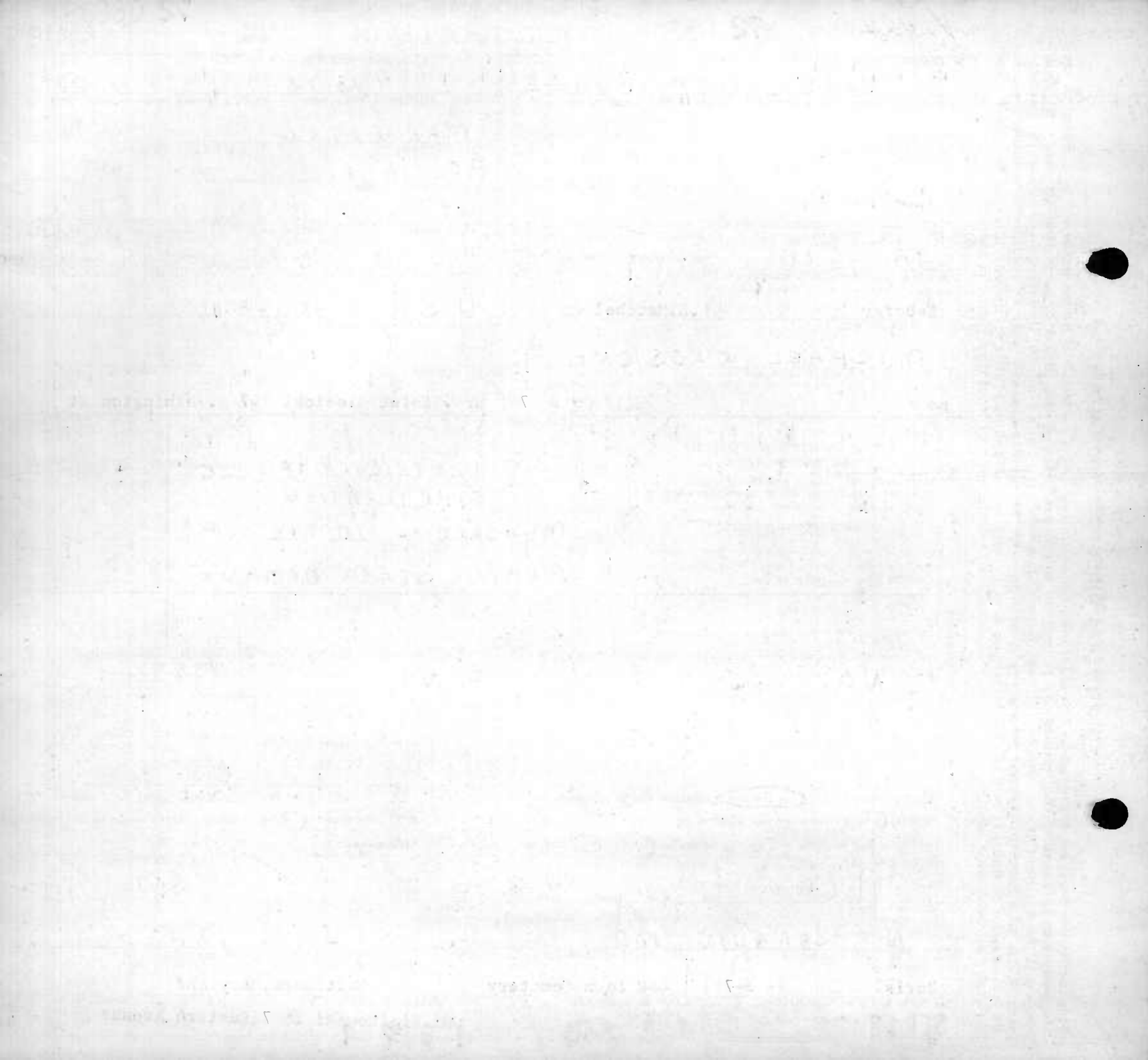




# FUNERAL DIRECTOR: IMPORTANT

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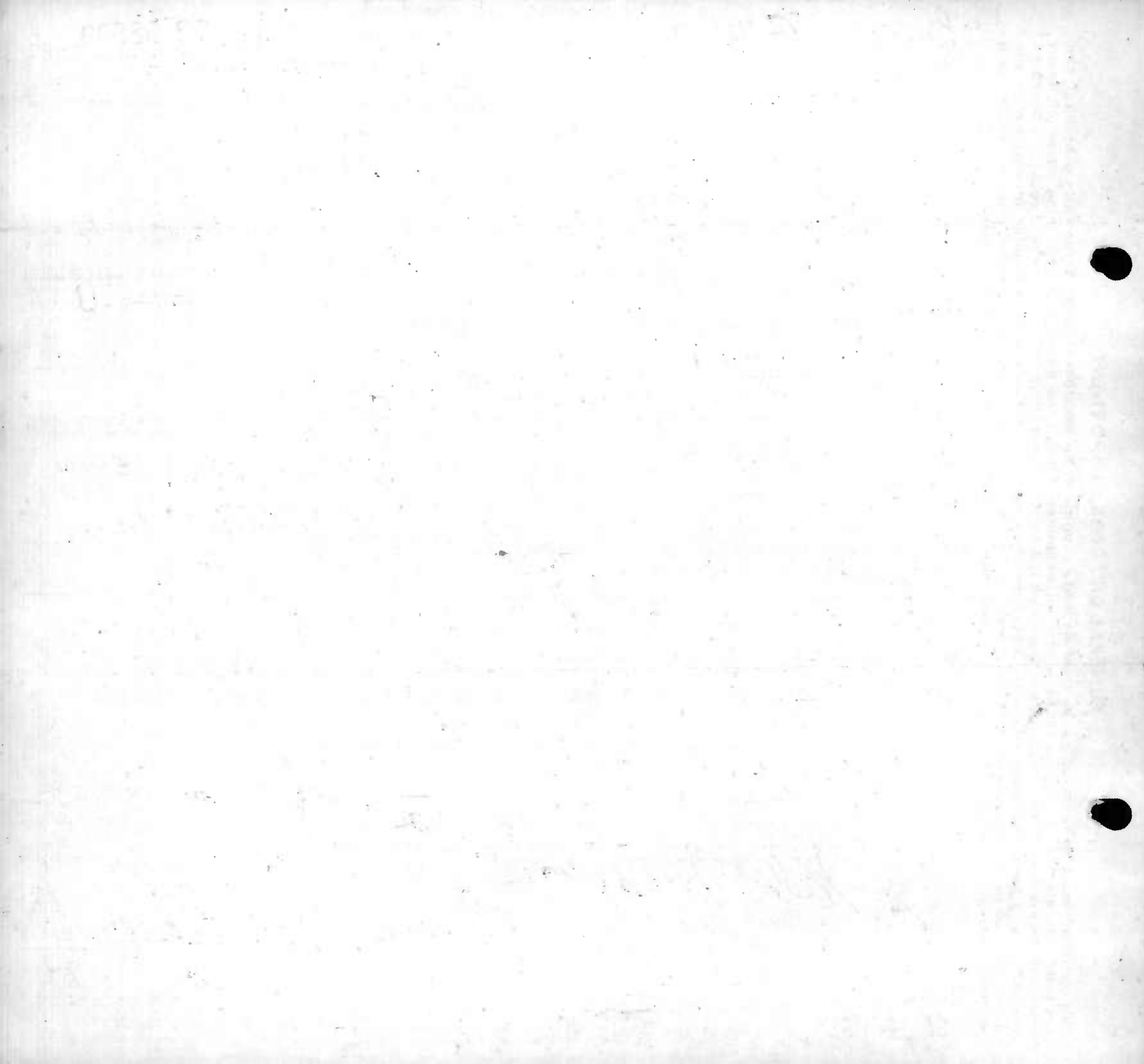
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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|---------------------------------------|
| 72 08898                                                                                                                                                                                                                                                                                                                                        |              | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                           |  | REG. NO. 72 08898                                                                             |                                       |
| BIRTH NO. K-422                                                                                                                                                                                                                                                                                                                                 |              | 72 08898                                                                                                                                                                                   |  | CERTIFICATE OF DEATH                                                                          |                                       |
| 1. NAME OF DECEASED<br>(Type or Print) KLOSICKI MICHAEL                                                                                                                                                                                                                                                                                         |              | 2. DATE AND HOUR OF DEATH<br>9.13.72 6:50 P.M.                                                                                                                                             |  |                                                                                               |                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                          |              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY                                                                                |  |                                                                                               |                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>37 301 ST. PAUL PLACE                                                                                                                                                                                                                                                                                   |              | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>MERCY HOSPITAL                                                                                                     |  | C. CITY OR TOWN<br>BALTIMORE                                                                  |                                       |
|                                                                                                                                                                                                                                                                                                                                                 |              |                                                                                                                                                                                            |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                       |
|                                                                                                                                                                                                                                                                                                                                                 |              | E. STREET AND NUMBER<br>247 S. WASHINGTON ST.                                                                                                                                              |  |                                                                                               |                                       |
| 5. SEX<br>m                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br>w | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                           |  | 8. DATE OF BIRTH<br>7.12.08                                                                   | 9. AGE (In years lost birthday)<br>64 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                                                                                                                                                          |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>L.E. Metchel Co                                                                                                                                       |  | 11. BIRTHPLACE (State or foreign country)<br>USA-MARYLAND                                     |                                       |
| 13. FATHER'S NAME<br>MICHAEL KLOSICKI                                                                                                                                                                                                                                                                                                           |              | 14. MOTHER'S MAIDEN NAME<br>?                                                                                                                                                              |  |                                                                                               |                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                  |              | 16. SOCIAL SECURITY NO.<br>212 05 2027                                                                                                                                                     |  | 17. INFORMANT<br>Mrs. Violet Klosicki 247 S. Washington St                                    |                                       |
| 18. 410.9 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |              | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>VENTRICULATORY FIBRILLATION<br>(B) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:<br>(C) BRAIN STEM DAMAGE |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                          |              |                                                                                                                                                                                            |  |                                                                                               |                                       |
| 19A. DATE OF OPERATION<br>NO                                                                                                                                                                                                                                                                                                                    |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                           |  | 20A. AUTOPSY? (Yes or No)<br>NO                                                               |                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                               |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                       |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                    |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                  |  | 21F. HOW DID INJURY OCCUR?                                                                    |                                       |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 9 1972 to Sept 13 1972, that (I) (we) last saw the deceased alive on Sept 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                               |              |                                                                                                                                                                                            |  |                                                                                               |                                       |
| 23A. SIGNATURE<br>N. F. JOAQUIN MD                                                                                                                                                                                                                                                                                                              |              | 23B. DATE SIGNED<br>Sept 13, 1972                                                                                                                                                          |  | 23C. PHYSICIAN'S NAME (Type)<br>N. F. JOAQUIN MD                                              |                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                              |              | 24B. DATE<br>9-16-72                                                                                                                                                                       |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                                       |                                       |
| 24D. LOCATION (City, town, or county)<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                    |              | 24E. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                             |  | 24F. NAME OF REGISTRAR<br>Wm. Fialkowski                                                      |                                       |
| 24G. ADDRESS<br>2007 Eastern Avenue                                                                                                                                                                                                                                                                                                             |              | 24H. FUNERAL DIRECTOR                                                                                                                                                                      |  |                                                                                               |                                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

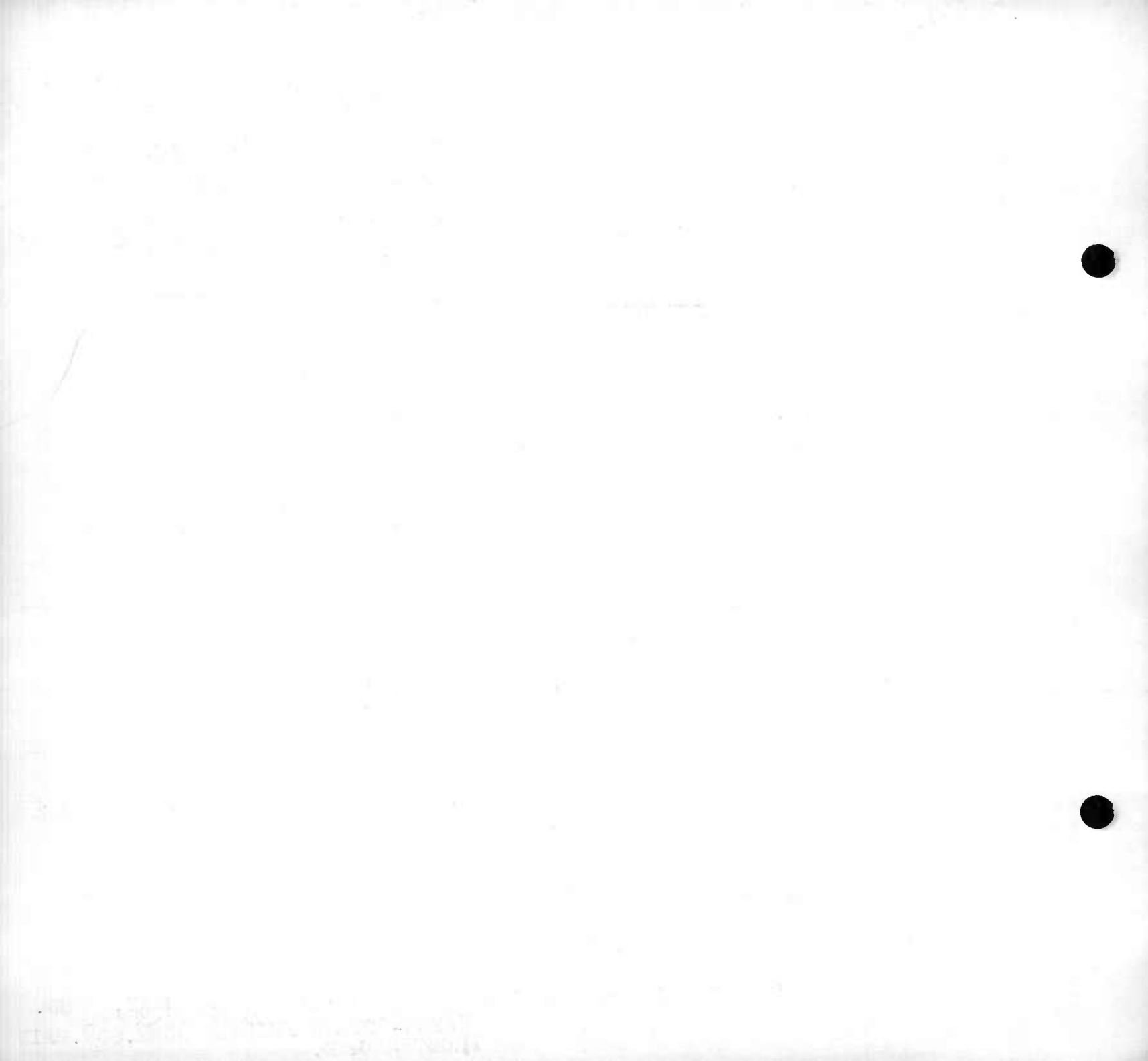
| Baltimore City Health Department                                                                                                                                                                              |  |  |                                                                                         | REG. NO. 72 08839        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------|--------------------------|--|
| B-652 72 08839                                                                                                                                                                                                |  |  |                                                                                         | STATE OF MARYLAND - DHMH |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                        |  |  | 2. DATE AND HOUR OF DEATH                                                               |                          |  |
| Bertha Burns                                                                                                                                                                                                  |  |  | 9/13/72 2:55 P.M.                                                                       |                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                        |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                  |  |  | A. STATE B. COUNTY                                                                      |                          |  |
| 90 CATON MANOR WILKENS AVE                                                                                                                                                                                    |  |  | Maryland 1902                                                                           |                          |  |
| 5. SEX                                                                                                                                                                                                        |  |  | 6. RACE                                                                                 |                          |  |
| F                                                                                                                                                                                                             |  |  | W                                                                                       |                          |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                    |  |  | 8. DATE OF BIRTH                                                                        |                          |  |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                 |  |  | 7/13/1887                                                                               |                          |  |
| 9. AGE (In years lost birthday)                                                                                                                                                                               |  |  | 85                                                                                      |                          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                   |  |  | 11. BIRTHPLACE (State or foreign country)                                               |                          |  |
| Nurse                                                                                                                                                                                                         |  |  | Maryland                                                                                |                          |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                             |  |  | 12. CITIZEN OF WHAT COUNTRY?                                                            |                          |  |
| Retired                                                                                                                                                                                                       |  |  | Yes U.S.A.                                                                              |                          |  |
| 13. FATHER'S NAME                                                                                                                                                                                             |  |  | 14. MOTHER'S MAIDEN NAME                                                                |                          |  |
| Joseph Rawlings                                                                                                                                                                                               |  |  | Fowler                                                                                  |                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                      |  |  | 16. SOCIAL SECURITY NO.                                                                 |                          |  |
| No                                                                                                                                                                                                            |  |  | 220-30-5805                                                                             |                          |  |
| 17. INFORMANT                                                                                                                                                                                                 |  |  | ADDRESS                                                                                 |                          |  |
| Mrs Bernadine Bailey                                                                                                                                                                                          |  |  | 1901 Lemon St.                                                                          |                          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                            |  |  | CAUSE OF DEATH                                                                          |                          |  |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)                                                                  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                     |                          |  |
| ANTECEDENT CAUSES                                                                                                                                                                                             |  |  | Chronic Pancreatitis 10 yrs                                                             |                          |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                     |  |  | (B) Cholecystitis-Cholelithiasis 15 yrs                                                 |                          |  |
| II                                                                                                                                                                                                            |  |  | (C)                                                                                     |                          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                              |  |  | Sarcocoele + Sarcocoele 10 yrs                                                          |                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                        |  |  | 20A. AUTOPSY? (Yes or No)                                                               |                          |  |
| 0                                                                                                                                                                                                             |  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |                          |  |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                              |  |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                          |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                      |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                |                          |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                               |  |  | 21E. INJURY OCCURRED                                                                    |                          |  |
| (APPROX.)                                                                                                                                                                                                     |  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |                          |  |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                    |  |  | 22. I certify that (I) (the hospital) attended the deceased from 19 55 to Sept 13 19 72 |                          |  |
| that (I) (we) last saw the deceased alive on Sept 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  | 23A. SIGNATURE                                                                          |                          |  |
| 23B. DATE SIGNED                                                                                                                                                                                              |  |  | 23C. PHYSICIAN'S NAME (Type)                                                            |                          |  |
| Sept 13, 1972                                                                                                                                                                                                 |  |  | J. Nelson McKay MD                                                                      |                          |  |
| 23D. ADDRESS                                                                                                                                                                                                  |  |  | 24A. REMOVAL (Specify)                                                                  |                          |  |
| 1132 N. Rollins Rd. Baltimore Md 21228                                                                                                                                                                        |  |  | BURIAL                                                                                  |                          |  |
| 24B. DATE                                                                                                                                                                                                     |  |  | 24C. NAME OF CEMETERY OR CREMATORY                                                      |                          |  |
| 9/18/72                                                                                                                                                                                                       |  |  | BALTIMORE NATIONAL                                                                      |                          |  |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                 |  |  | 25A. DATE REC'D BY HEALTH OFF.                                                          |                          |  |
| Fredrick Ave Md.                                                                                                                                                                                              |  |  | SEP 18 1972                                                                             |                          |  |
| 25B. NAME OF REGISTRAR                                                                                                                                                                                        |  |  | 25C. FUNERAL DIRECTOR                                                                   |                          |  |
| Sidney Wilson                                                                                                                                                                                                 |  |  | Thomas J. KENNY Inc 1600 Hollins St                                                     |                          |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                         |         |                                                                                          |                                                                                       | REG. NO. 72 08900                                                        |                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------|
| C-600 72 08900                                                                                                                                                                                                                                                                                           |         |                                                                                          |                                                                                       | STATE OF MARYLAND-DEMD                                                   |                                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                |         | 1. NAME OF DECEASED<br>(Type or Print)                                                   |                                                                                       | 2. DATE AND HOUR OF DEATH                                                |                                                          |
|                                                                                                                                                                                                                                                                                                          |         | Lillie Beall Carr                                                                        |                                                                                       | 9 / 12 / 72 1:25 P.M.                                                    |                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                   |         |                                                                                          | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                                                          |                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                             |         |                                                                                          | A. STATE B. COUNTY                                                                    |                                                                          |                                                          |
| University of Maryland<br>38                                                                                                                                                                                                                                                                             |         |                                                                                          | Maryland Allegany Co                                                                  |                                                                          |                                                          |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          | C. CITY OR TOWN                                                                       |                                                                          | D. INSIDE CITY LIMITS?                                   |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          | Eckhart                                                                               |                                                                          | YES <input type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          | E. STREET AND NUMBER                                                                  |                                                                          |                                                          |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          | Box 128 5100                                                                          |                                                                          |                                                          |
| 5. SEX                                                                                                                                                                                                                                                                                                   | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH                                                                      | 9. AGE (In years last birthday)                                          | 10. If Under 1 Yr. Months Days                           |
| F                                                                                                                                                                                                                                                                                                        | CAUC    | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 12/22/23                                                                              | 48                                                                       |                                                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                              |         |                                                                                          | 10B. KIND OF BUSINESS OR INDUSTRY                                                     |                                                                          | 11. BIRTHPLACE (State or foreign country)                |
| Housewife                                                                                                                                                                                                                                                                                                |         |                                                                                          | OWN HOME                                                                              |                                                                          | MD.                                                      |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                        |         |                                                                                          | 14. MOTHER'S MAIDEN NAME                                                              |                                                                          |                                                          |
| Thomas Willison                                                                                                                                                                                                                                                                                          |         |                                                                                          | Lillie Twist                                                                          |                                                                          |                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                 |         |                                                                                          | 16. SOCIAL SECURITY NO.                                                               |                                                                          | 17. INFORMANT ADDRESS                                    |
| NO N.A.                                                                                                                                                                                                                                                                                                  |         |                                                                                          | None                                                                                  |                                                                          | chant                                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                        |         |                                                                                          | CAUSE OF DEATH                                                                        |                                                                          |                                                          |
| 396.91                                                                                                                                                                                                                                                                                                   |         |                                                                                          | CARDIAC FAILURE FROM INADEQUATE MYOCARDIAL RESERVE                                    |                                                                          |                                                          |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                        |         |                                                                                          | (A) IMMEDIATE CAUSE                                                                   |                                                                          |                                                          |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                |         |                                                                                          | DUE TO, OR AS A CONSEQUENCE OF:                                                       |                                                                          |                                                          |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          | MITRAL STENOSIS AND INSUFFICIENCY AND AORTIC INSUFFICIENCY                            |                                                                          |                                                          |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |                                                                          |                                                          |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                   |                                                                          |                                                          |
| II                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                                                                                       |                                                                          |                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                         |         |                                                                                          |                                                                                       |                                                                          |                                                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                                                                                       | 20A. AUTOPSY? (Yes or No)                                                |                                                          |
| 19/1/72                                                                                                                                                                                                                                                                                                  |         | Aortic and Mitral Valve Disease                                                          |                                                                                       | NO                                                                       |                                                          |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                    |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                          |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          |                                                                                       |                                                                          |                                                          |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                            |         | 21E. INJURY OCCURRED                                                                     |                                                                                       | 21F. HOW DID INJURY OCCUR?                                               |                                                          |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                              |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                                                                                       |                                                                          |                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from 8/28 1972 to 9/12 1972 that (I) (we) last saw the deceased alive on 9/11 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death. |         |                                                                                          |                                                                                       |                                                                          |                                                          |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                           |         |                                                                                          |                                                                                       | 23B. DATE SIGNED                                                         |                                                          |
| John R. Patterson                                                                                                                                                                                                                                                                                        |         |                                                                                          |                                                                                       | 9/12/72                                                                  |                                                          |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                             |         |                                                                                          |                                                                                       | 23D. ADDRESS                                                             |                                                          |
| John R. Patterson M.D.                                                                                                                                                                                                                                                                                   |         |                                                                                          |                                                                                       | Univ. Md. Hosp.                                                          |                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                 |         | 24B. DATE                                                                                |                                                                                       | 24C. NAME OF CEMETERY OR CREMATORY                                       |                                                          |
| BURIAL                                                                                                                                                                                                                                                                                                   |         | 9/15/72                                                                                  |                                                                                       | ECKHART CEMETERY                                                         |                                                          |
|                                                                                                                                                                                                                                                                                                          |         |                                                                                          |                                                                                       | ECKHART ALLEGANY MD.                                                     |                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                          |         | 25B. NAME OF REGISTRAR                                                                   |                                                                                       | 25C. FUNERAL DIRECTOR                                                    |                                                          |
| SEP 18 1972                                                                                                                                                                                                                                                                                              |         | Frostburg                                                                                |                                                                                       | HAFER-SOWERS FUNERAL HOME, 60W. MAIN FROSTBURG, MD.                      |                                                          |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                             |           |                                                                                                                                                                 |                          | REG. NO. 72 08901                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------|
| BIRTH NO. 7-630                                                                                                                                                                                                                                                                                                                      |           | NAME OF DECEASED (Type or Print) Katherine #1020                                                                                                                |                          | DATE AND HOUR OF DEATH 9-15-72 11:35 A.M.                                |
| PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                  |           | USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY                                                        |                          |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>42 Sinai Hospital of Md.                                                                                                                                                                                                |           | C. CITY OR TOWN D. INSIDE CITY LIMITS?<br>Baltimore Md. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |                          |                                                                          |
| E. STREET AND NUMBER<br>1023 Dimick Rd                                                                                                                                                                                                                                                                                               |           | F. ZIP CODE<br>21215                                                                                                                                            |                          |                                                                          |
| 5. SEX Female                                                                                                                                                                                                                                                                                                                        | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH 7-16-22 | 9. AGE (In years last birthday) 50                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Bar maid                                                                                                                                                                                                                              |           | 10B. KIND OF BUSINESS OR INDUSTRY<br>Bar                                                                                                                        |                          | 11. BIRTHPLACE (State or foreign country)<br>West Virginia               |
| 13. FATHER'S NAME<br>Ira Manns                                                                                                                                                                                                                                                                                                       |           | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                                                        |                          |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                       |           | 16. SOCIAL SECURITY NO.<br>-                                                                                                                                    |                          | 17. INFORMANT<br>Mrs. Jimmie Jeffries                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |           | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>CANCER - Malignant<br>C. Breast<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 years<br>2 years   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                               |           |                                                                                                                                                                 |                          |                                                                          |
| 19A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                             |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                |                          | 20A. AUTOPSY? (Yes or No) yes                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                       |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                        |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                            |           | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                       |                          | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) (this hospital) attended the deceased from 8:30 to 9:15 that (I) (we) last saw the deceased alive on 9-15-72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                         |           |                                                                                                                                                                 |                          |                                                                          |
| 23A. SIGNATURE<br>Felix Dubner                                                                                                                                                                                                                                                                                                       |           | 23B. DATE SIGNED<br>9-15-72                                                                                                                                     |                          | 23C. PHYSICIAN'S NAME (Type)<br>Felix Dubner                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                   |           | 24B. DATE<br>9/18/72                                                                                                                                            |                          | 24C. NAME OF CEMETERY OR CREMATORY<br>Green Haven Cem.                   |
| 24D. LOCATION<br>Baltimore                                                                                                                                                                                                                                                                                                           |           | 24E. LOCATION (City, town, or county) (State)<br>Baltimore Md.                                                                                                  |                          |                                                                          |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                                                       |           | 25B. NAME OF REGISTRAR<br>Audrey H. Wilson                                                                                                                      |                          | 25C. FUNERAL DIRECTOR<br>John J. Brown & Son Inc.                        |
| 25D. ADDRESS<br>991 St. Johns                                                                                                                                                                                                                                                                                                        |           |                                                                                                                                                                 |                          |                                                                          |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

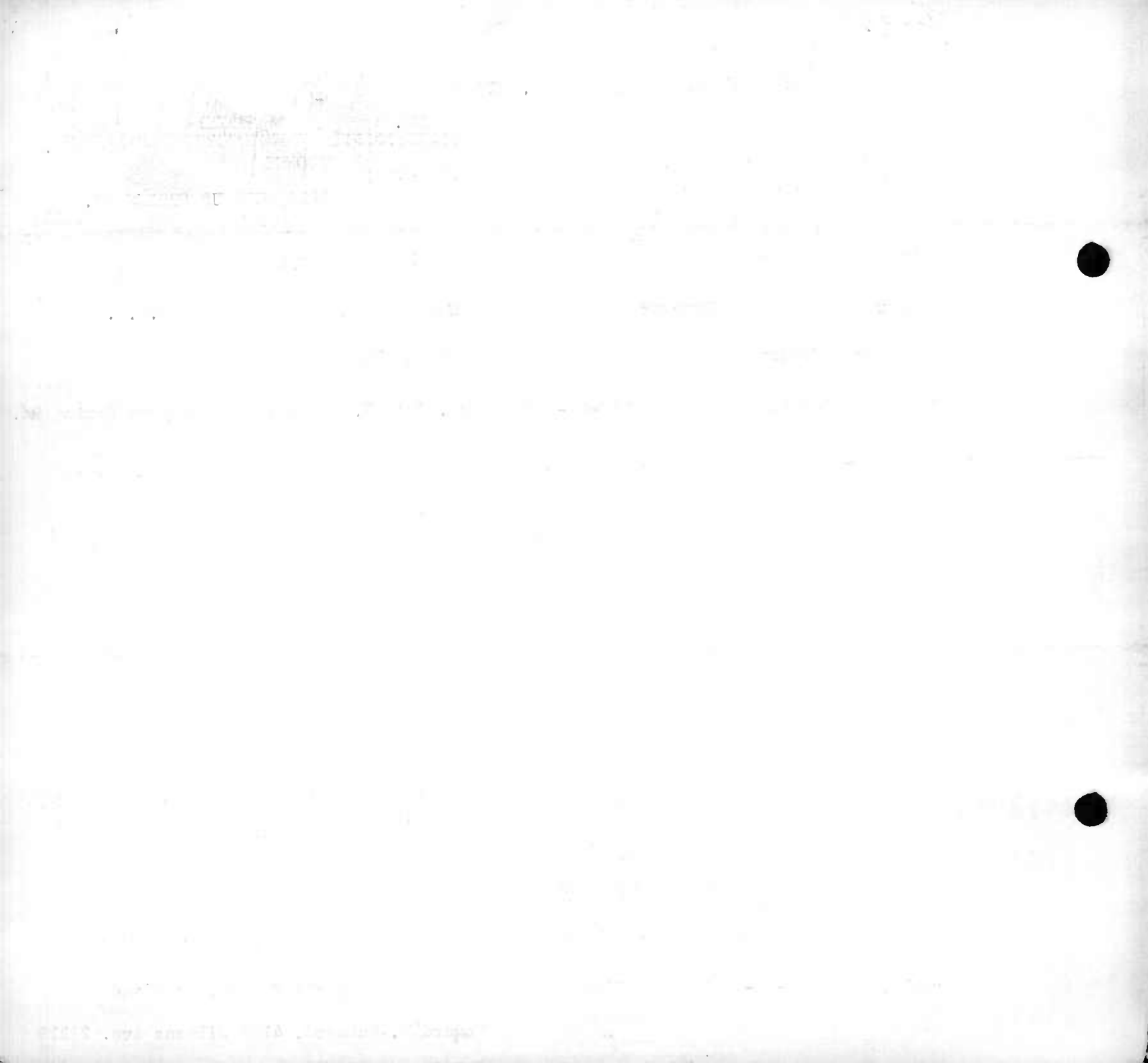
|                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  |                                                                                                                                         |                                                  |                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| K-400                                                                                                                                                                                                                                                                                                                                                           |                         | 72 08902                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                        |                                                  | 72 08902                                                                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                       |                         | CERTIFICATE OF DEATH                                                                                                                                        |  |                                                                                                                                         |                                                  | REG. NO.                                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Charles Clifford Kelley</i>                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><i>Sept 13, 1972</i>                                                                                       |                                                  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MARYLAND</i> B. COUNTY <i>2712</i> |                                                  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>Anderson Nursing Home</i>                                                                                                                                                                                                                       |                         |                                                                                                                                                             |  | C. CITY OR TOWN<br><i>BALTIMORE</i>                                                                                                     |                                                  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  | E. STREET AND NUMBER<br><i>5911 BRACKENRIDGE AVE</i>                                                                                    |                                                  |                                                                                               |  |
| 5. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                           | 6. RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>April 8, 1914</i>                                                                                                | 9. AGE (In years last birthday)<br><i>58 yrs</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>FARMER</i>                                                                                                                                                                                                                                                    |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><i>VIRGINIA</i>                                                                            |                                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                 |  |
| 13. FATHER'S NAME<br><i>James Kelley Jr.</i>                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><i>Felicia Hubbard</i>                                                                                      |                                                  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>-</i>                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br><i>-</i>                                                                                                     |                                                  | 17. INFORMANT ADDRESS<br><i>Ardis O'Connor - Same</i>                                         |  |
| 18. <i>412.3 I</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                            |                                                  |                                                                                               |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                   |                         |                                                                                                                                                             |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>(1) Arterio Sclerotic Heart Disease</i>                                       |                                                  | <i>10 yrs</i>                                                                                 |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |  | (B) <i>(2) Hemorrhagic Cystitis</i>                                                                                                     |                                                  | <i>6 days</i>                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  | (C) <i>Generalized Arterio Sclerosis</i>                                                                                                |                                                  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                          |                         |                                                                                                                                                             |  |                                                                                                                                         |                                                  |                                                                                               |  |
| 19A. DATE OF OPERATION<br><i>None</i>                                                                                                                                                                                                                                                                                                                           |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                               |                                                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                           |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                |                                                  |                                                                                               |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                       |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                              |                                                  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>May 15</i> 19 <i>68</i> to <i>Sept. 13</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>Sept. 11</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                         |                                                                                                                                                             |  |                                                                                                                                         |                                                  |                                                                                               |  |
| 23A. SIGNATURE<br><i>Earl L. Chambers</i>                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>         |                                                  | 23B. DATE SIGNED<br><i>9/14/72</i>                                                            |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Earl L. Chambers</i>                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |  | 23D. ADDRESS<br><i>100 - W. Golding Balto. Md</i>                                                                                       |                                                  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                       |                         | 24B. DATE<br><i>9-16-72</i>                                                                                                                                 |  | 24C. NAME of CEMETERY or CREMATORY<br><i>Rehobeth Cemetery</i>                                                                          |                                                  | 24D. LOCATION (City, town, or county) (State)<br><i>KILMARNACK, VIRGINIA</i>                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 18 1972</i>                                                                                                                                                                                                                                                                                                           |                         | 25B. NAME OF REGISTRAR<br><i>Sidney W. Wilson</i>                                                                                                           |  | 25C. FUNERAL DIRECTOR ADDRESS<br><i>Ardis O'Connor - Same</i>                                                                           |                                                  |                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                       |         |                                                                                                                     |                          | REG. NO.                                                                 |                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------|--------------------------------|
| 7-360                                                                                                                                                                                                                                                                                                                  |         | 72 08903                                                                                                            |                          | 72 08903                                                                 |                                |
| BIRTH NO.                                                                                                                                                                                                                                                                                                              |         | 1. NAME OF DECEASED<br>(Type or Print)                                                                              |                          | 2. DATE AND HOUR OF DEATH                                                |                                |
|                                                                                                                                                                                                                                                                                                                        |         | HARRY W. FITTRO                                                                                                     |                          | Sept 13-1972 10:15 A.M.                                                  |                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                 |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                               |                          |                                                                          |                                |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)                                                                                                                                                                                                           |         | A. STATE MD. B. COUNTY BALTIMORE                                                                                    |                          |                                                                          |                                |
|                                                                                                                                                                                                                                                                                                                        |         | C. CITY OR TOWN LAWSOWNE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          |                                                                          |                                |
| Sinal Hospital of Baltimore Inc                                                                                                                                                                                                                                                                                        |         | E. STREET AND NUMBER 1924 SULPHUR SPRING RD. 21227                                                                  |                          |                                                                          |                                |
|                                                                                                                                                                                                                                                                                                                        |         | AS ABOVE                                                                                                            |                          |                                                                          |                                |
| 5. SEX                                                                                                                                                                                                                                                                                                                 | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                               | 8. DATE OF BIRTH         | 9. AGE (In years last birthday)                                          | 10. If Under 1 Yr. Months Days |
| Male                                                                                                                                                                                                                                                                                                                   | White   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                  | 6-16-30 1928             | 44                                                                       |                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                            |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                   |                          | 12. CITIZEN OF WHAT COUNTRY?                                             |                                |
| Welder                                                                                                                                                                                                                                                                                                                 |         | Proctor Silex                                                                                                       |                          | U.S.A.                                                                   |                                |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                      |         |                                                                                                                     | 14. MOTHER'S MAIDEN NAME |                                                                          |                                |
| Roscoe Fittro                                                                                                                                                                                                                                                                                                          |         |                                                                                                                     | Madge Floyd              |                                                                          |                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                               |         | 16. SOCIAL SECURITY NO.                                                                                             |                          | 17. INFORMANT                                                            |                                |
| Yes                                                                                                                                                                                                                                                                                                                    |         | Korean                                                                                                              |                          | Mrs. Judy I. Fittro, 1924 Sulphur Spring Rd.                             |                                |
|                                                                                                                                                                                                                                                                                                                        |         | 217-24-1344                                                                                                         |                          | ADDRESS 21227                                                            |                                |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                     |         |                                                                                                                     |                          |                                                                          |                                |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                         |         |                                                                                                                     |                          |                                                                          |                                |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                           |         |                                                                                                                     |                          |                                                                          |                                |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                      |         |                                                                                                                     |                          |                                                                          |                                |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                              |         |                                                                                                                     |                          |                                                                          |                                |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary failure</u>                                                                                                                                                                                                                                            |         |                                                                                                                     |                          |                                                                          |                                |
| (B) DUE TO, OR AS A CONSEQUENCE OF: <u>undermining of lung in</u>                                                                                                                                                                                                                                                      |         |                                                                                                                     |                          |                                                                          |                                |
| (C) <u>metastasis</u>                                                                                                                                                                                                                                                                                                  |         |                                                                                                                     |                          |                                                                          |                                |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                           |         |                                                                                                                     |                          |                                                                          |                                |
| <u>2 weeks</u>                                                                                                                                                                                                                                                                                                         |         |                                                                                                                     |                          |                                                                          |                                |
| <u>4 weeks</u>                                                                                                                                                                                                                                                                                                         |         |                                                                                                                     |                          |                                                                          |                                |
| II                                                                                                                                                                                                                                                                                                                     |         |                                                                                                                     |                          |                                                                          |                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                       |         |                                                                                                                     |                          |                                                                          |                                |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                    |                          | 20A. AUTOPSY? (Yes or No)                                                |                                |
| 0                                                                                                                                                                                                                                                                                                                      |         |                                                                                                                     |                          |                                                                          |                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                            |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                |
|                                                                                                                                                                                                                                                                                                                        |         |                                                                                                                     |                          |                                                                          |                                |
| 21D. TIME OF INJURY (APPROX)                                                                                                                                                                                                                                                                                           |         | 21E. INJURY OCCURRED                                                                                                |                          | 21F. HOW DID INJURY OCCUR?                                               |                                |
|                                                                                                                                                                                                                                                                                                                        |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                   |                          |                                                                          |                                |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-5-72</u> to <u>9-13-72</u> that (I) (we) last saw the deceased alive on <u>9-13-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                                                     |                          |                                                                          |                                |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                         |         |                                                                                                                     |                          | 23B. DATE SIGNED                                                         |                                |
| <u>Julius Gutierrez M.D.</u>                                                                                                                                                                                                                                                                                           |         |                                                                                                                     |                          |                                                                          |                                |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                           |         |                                                                                                                     |                          | 23D. ADDRESS                                                             |                                |
| <u>Julius Gutierrez M.D.</u>                                                                                                                                                                                                                                                                                           |         |                                                                                                                     |                          | <u>Sinal Hospital of Baltimore.</u>                                      |                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                               |         | 24B. DATE                                                                                                           |                          | 24C. NAME of CEMETERY or CREMATORY                                       |                                |
| Burial                                                                                                                                                                                                                                                                                                                 |         | 9-16-1972                                                                                                           |                          | Lake View Memorial Park                                                  |                                |
|                                                                                                                                                                                                                                                                                                                        |         |                                                                                                                     |                          | Carroll County, Maryland                                                 |                                |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                        |         | 25B. NAME OF REGISTRAR                                                                                              |                          | 25C. FUNERAL DIRECTOR                                                    |                                |
| SEP 18 1972                                                                                                                                                                                                                                                                                                            |         | <u>Adrian M. [unclear]</u>                                                                                          |                          | Howard H. Hubbard, 4107 Wilkens Ave. 21229                               |                                |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

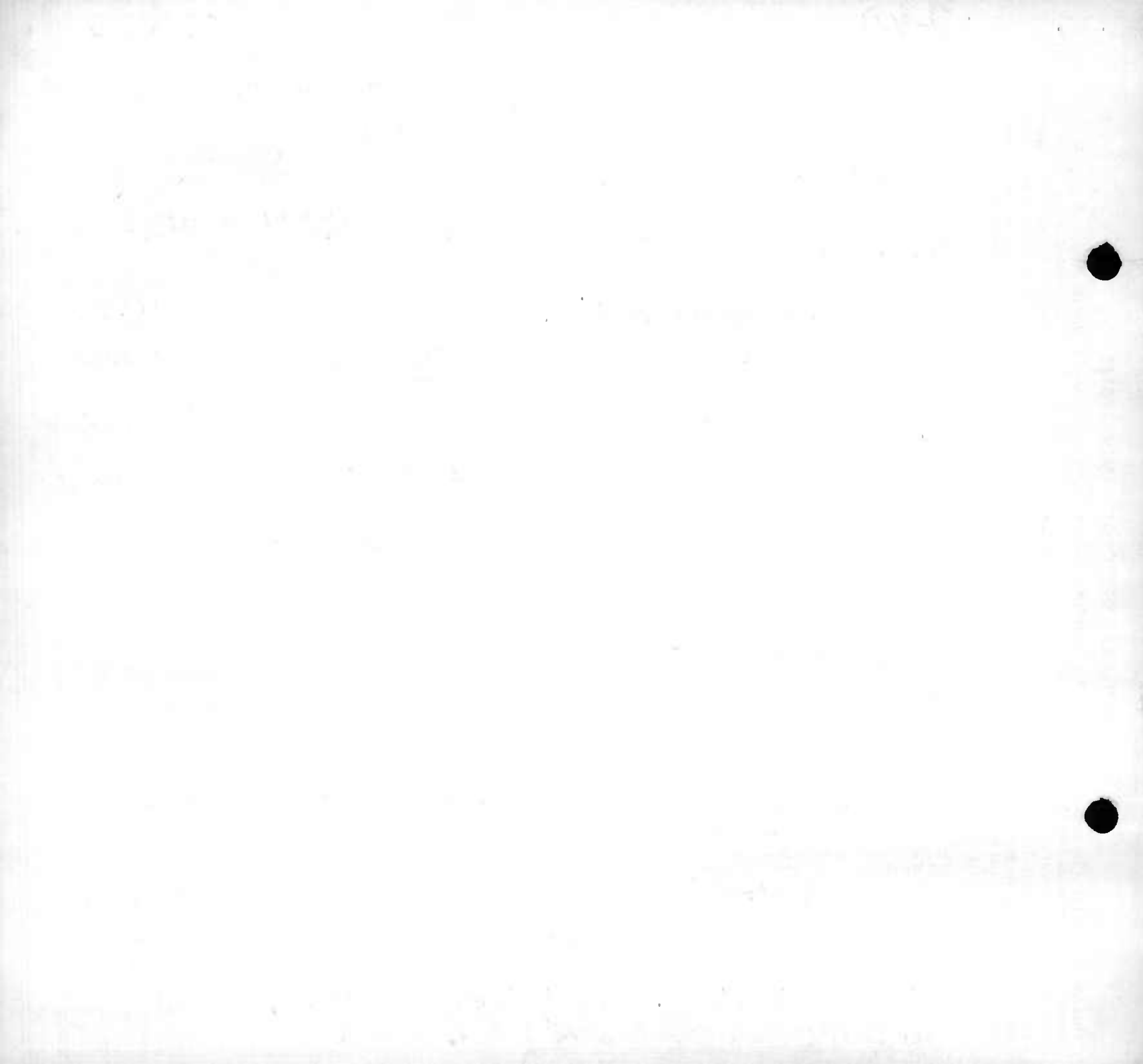
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | REG. NO. 72 08904                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 0-165 72 08904                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  | CERTIFICATE OF DEATH                                                                                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Margaret J. O'Brien</u>                                      |  | 2. DATE AND HOUR OF DEATH<br><u>9-12-72</u> <u>12:30 P.M.</u>                                                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><u>Lutheran Hospital</u>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>2006</u> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>46</u><br><u>Lutheran Hospital</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |
| 5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                              |  |                                                                                                        |  | E. STREET AND NUMBER <u>3144 STRICKLAND STREET</u><br><u>XXXXXX XXXXX XXXXX XXXXX XXXXX</u>                                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>                                                                                                                                                                                                                                                                                                                   |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                      |  | 8. DATE OF BIRTH <u>12-27-88</u> 9. AGE (In years lost birthday) <u>81</u>                                                              |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                           |  |
| 13. FATHER'S NAME<br><u>Charles Diffendal</u>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | 14. MOTHER'S MAIDEN NAME<br><u>Harriett Calliger</u>                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO.<br><u>215-18-6398</u>                                                          |  | 17. INFORMANT<br><u>Mrs. Rena Smith, 2526 Marbourne Ave. 21230</u>                                                                      |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><u>Acute Myocardial Infarction</u><br><u>Coronary Heart Failure</u> |  |                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>1 day</u>                                                            |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                         |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No) <u>No</u>                                                                                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Infallibly medical examined                                                                                                                                                                                                                                                                                                                |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                       |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                              |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-11-72</u> to <u>9-12-72</u> that (I) (we) last saw the deceased alive on <u>9-12-72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                         |  |                                                                                                        |  |                                                                                                                                         |  |
| 23A. SIGNATURE<br><u>Louderes M. Victoria, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | 23B. DATE SIGNED<br><u>9-12-72</u>                                                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>LOUDES M. VICTORIA, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | 23D. ADDRESS<br><u>Lutheran Hospital of Maryland</u>                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                       |  | 24B. DATE<br><u>9-15-1972</u>                                                                          |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral Cemetery</u>                                                                     |  |
| 24D. LOCATION<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                     |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 18 1972</u>                                                  |  |                                                                                                                                         |  |
| 25B. NAME OF REGISTRAR<br><u>Howard H. Hubbard</u>                                                                                                                                                                                                                                                                                                                                                                              |  | 25C. FUNERAL DIRECTOR<br><u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>                             |  |                                                                                                                                         |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | REG. NO. <b>72 08905</b>                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. <b>0-160</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN E. OVER</b>                                             |  | 2. DATE AND HOUR OF DEATH<br><b>9. 14. 72 2:53 P. M.</b>                                                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>35 Church Home &amp; Hospital.</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>603</b>                           |  |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. RACE <b>W</b>                                                                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Reta Truck Driver Carroll Ind. Oil</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Co.</b>                                                        |  | 8. DATE OF BIRTH <b>4. 19. 03</b>                                                                                                                           |  |
| 13. FATHER'S NAME<br><b>HARRY OVER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. MOTHER'S MAIDEN NAME<br><b>XXXXXXXXXXXX Amelia Rogers</b>                                          |  | 9. AGE (In years last birthday) <b>69</b>                                                                                                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16. SOCIAL SECURITY NO.<br><b>212-02-1464</b>                                                          |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                |  |
| 17. INFORMANT<br><b>Hospital Chart</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS                                                                                                |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                             |  |
| 18. <b>519.3 I</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>(A) IMMEDIATE CAUSE <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF: <u>7 days</u></b><br><b>(B) <u>COPD, Emphysema, ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Long Standing</u></b><br><b>(C) _____</b> |  |                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br><b>9</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9. 7. 19 72</b> to <b>9. 14. 19 72</b> that (I) (we) last saw the deceased alive on <b>9. 14. 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                          |  |                                                                                                        |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><b>Satpal Singh M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23B. DATE SIGNED<br><b>9. 14. 72</b>                                                                   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>SATPAL SINGH M.D.</b>                                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24B. DATE<br><b>9/18/72</b>                                                                            |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Matthew's Cemetery</b>                                                                                         |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                  |  | 25B. NAME OF REGISTRAR<br><b>Adrian Whitton</b>                                                                                                             |  |
| 25C. FUNERAL DIRECTOR<br><b>5000 E. Baltimore St. Baltimore, Md. 21208</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | ADDRESS                                                                                                |  |                                                                                                                                                             |  |





| STATE OF MARYLAND - DEPT. OF HEALTH                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                         |  |                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| E-200 72 08906                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 72 08906                                                                                                                                                                 |  |                                                                                                                                                             |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                                                                          |  |                                                                                                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | REG. NO.                                                                                                                                                                 |  |                                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>William Stewart Echo                                                                                                                                                                                                                                                                                                                                                |  |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br>9 13 72 4:40 P.M.                             |  |                                                                                                                                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>38 University Hospital                                                                                                                                                                                                              |  |  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 13 72 4:40 P.M.                                                                                                      |  |                                                                                                                                                             |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 7. RACE<br>White                                                                                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>August 8, 1937                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 10. AGE (in years last birthday)<br>35                                                                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                                                                                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 13. FATHER'S NAME<br>Richard Stewart Echo 6232                                                                                                                           |  |                                                                                                                                                             |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Foreman                                                                                                                                                                                                                                                                                                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Gertrude Hoffmeister                                                                                                                         |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>YES 19 Oct. '55 - 18 Oct. '61                    |  |
| 17. SOCIAL SECURITY NO.<br>212-34-5087                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 18. INFORMANT (Name) 879-7850 ADDRESS<br>Mrs. Rose Echo 202 East MacPhail Road Bel Air, Maryland 21014                                                                   |  |                                                                                                                                                             |  |
| 19. E812.0 CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |  |                                                                                                                                                             |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                  |  |  |  | (A) IMMEDIATE CAUSE<br>Multiple injuries including crushed chest                                                                                                         |  |                                                                                                                                                             |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                      |  |                                                                                                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  |  |  | (C)                                                                                                                                                                      |  |                                                                                                                                                             |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |                                                                                                                                                             |  |
| 21. AUTOPSY? (Yes or No)<br>Yes                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |                                                                                                                                                                          |  |                                                                                                                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  |  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street                                                                       |  |                                                                                                                                                             |  |
| 22C. WHERE DID INJURY OCCUR?<br>Int. St. 755 & Route 24 6232                                                                                                                                                                                                                                                                                                                                                  |  |  |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br>9 13 72 3:59 P.M.                                                                                           |  |                                                                                                                                                             |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                             |  |  |  | 22F. HOW DID INJURY OCCUR?<br>Driver in auto-auto accident                                                                                                               |  |                                                                                                                                                             |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |                                                                                                                                                                          |  |                                                                                                                                                             |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Marvin S. Platt, M.D.                                                                                                                                                                                                                                                                                                                                           |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |                                                                                                                                                             |  |
| DATE SIGNED<br>9-14-72                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |                                                                                                                                                                          |  |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 24B. DATE<br>Sept. 16, 1972                                                                                                                                              |  |                                                                                                                                                             |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Bel Air Memorial Gardens                                                                                                                                                                                                                                                                                                                                                |  |  |  | 24D. LOCATION (City, town, or county) (State)<br>Bel Air, Harford Co., Maryland 21014                                                                                    |  |                                                                                                                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 25B. NAME OF REGISTRAR<br>Adm. J. H. Wilson                                                                                                                              |  |                                                                                                                                                             |  |
| 25C. FUNERAL DIRECTOR<br>Joseph William Foster                                                                                                                                                                                                                                                                                                                                                                |  |  |  | ADDRESS<br>W. Broadway & Williams St.<br>Bel Air, Maryland 21014                                                                                                         |  |                                                                                                                                                             |  |

| Name             |  | Class      |  | Grade    |  | Age |  | Date of Birth |  | Date of Admission |  | Date of Graduation |  |
|------------------|--|------------|--|----------|--|-----|--|---------------|--|-------------------|--|--------------------|--|
| John Smith       |  | St. John's |  | Freshman |  | 18  |  | Jan 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| James Brown      |  | St. John's |  | Freshman |  | 17  |  | Feb 15, 1900  |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Mary White       |  | St. John's |  | Freshman |  | 16  |  | Mar 10, 1900  |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Robert Green     |  | St. John's |  | Freshman |  | 19  |  | Dec 5, 1899   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Elizabeth Black  |  | St. John's |  | Freshman |  | 15  |  | Apr 20, 1900  |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| William Taylor   |  | St. John's |  | Freshman |  | 18  |  | Nov 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Margaret Jones   |  | St. John's |  | Freshman |  | 17  |  | Oct 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Thomas Wilson    |  | St. John's |  | Freshman |  | 16  |  | Sep 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Anna Davis       |  | St. John's |  | Freshman |  | 15  |  | Aug 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| George Miller    |  | St. John's |  | Freshman |  | 18  |  | Jul 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Charlotte Lee    |  | St. John's |  | Freshman |  | 17  |  | Jun 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Henry Clark      |  | St. John's |  | Freshman |  | 16  |  | May 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Isabella Hall    |  | St. John's |  | Freshman |  | 15  |  | Apr 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Frank Adams      |  | St. John's |  | Freshman |  | 18  |  | Mar 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Lucy King        |  | St. John's |  | Freshman |  | 17  |  | Feb 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Charles Wright   |  | St. John's |  | Freshman |  | 16  |  | Jan 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Sophia Scott     |  | St. John's |  | Freshman |  | 15  |  | Dec 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Edward Young     |  | St. John's |  | Freshman |  | 18  |  | Nov 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Frances Hill     |  | St. John's |  | Freshman |  | 17  |  | Oct 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Albert King      |  | St. John's |  | Freshman |  | 16  |  | Sep 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Mildred Lee      |  | St. John's |  | Freshman |  | 15  |  | Aug 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Harold Clark     |  | St. John's |  | Freshman |  | 18  |  | Jul 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Beatrice Hall    |  | St. John's |  | Freshman |  | 17  |  | Jun 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Clarence Adams   |  | St. John's |  | Freshman |  | 16  |  | May 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Evelyn King      |  | St. John's |  | Freshman |  | 15  |  | Apr 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Frederick Wright |  | St. John's |  | Freshman |  | 18  |  | Mar 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Gladys Scott     |  | St. John's |  | Freshman |  | 17  |  | Feb 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Herbert Young    |  | St. John's |  | Freshman |  | 16  |  | Jan 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Irene Hill       |  | St. John's |  | Freshman |  | 15  |  | Dec 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Jesse King       |  | St. John's |  | Freshman |  | 18  |  | Nov 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Lillian Lee      |  | St. John's |  | Freshman |  | 17  |  | Oct 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Maurice Clark    |  | St. John's |  | Freshman |  | 16  |  | Sep 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Nancy Hall       |  | St. John's |  | Freshman |  | 15  |  | Aug 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Oscar Adams      |  | St. John's |  | Freshman |  | 18  |  | Jul 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Pamela King      |  | St. John's |  | Freshman |  | 17  |  | Jun 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Quentin Wright   |  | St. John's |  | Freshman |  | 16  |  | May 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Rebecca Scott    |  | St. John's |  | Freshman |  | 15  |  | Apr 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Samuel Young     |  | St. John's |  | Freshman |  | 18  |  | Mar 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Teresa Hill      |  | St. John's |  | Freshman |  | 17  |  | Feb 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Ulysses King     |  | St. John's |  | Freshman |  | 16  |  | Jan 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Vivian Lee       |  | St. John's |  | Freshman |  | 15  |  | Dec 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Walter Clark     |  | St. John's |  | Freshman |  | 18  |  | Nov 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Xenia Hall       |  | St. John's |  | Freshman |  | 17  |  | Oct 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Yvonne Adams     |  | St. John's |  | Freshman |  | 16  |  | Sep 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |
| Zachary King     |  | St. John's |  | Freshman |  | 15  |  | Aug 1, 1900   |  | Sep 1, 1900       |  | Jun 1, 1901        |  |

WALTER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                          |                                           |                                                                                                                                                                                                                                                                                                                                                               |                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| <p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b><br/>(Type or Print)</p> <p style="font-size: 1.5em; text-align: center;">John Hicks</p>                                                                                                                                                                                                                                                            |                                           | <p><b>2. DATE AND HOUR OF DEATH</b></p> <p style="font-size: 1.5em; text-align: center;">9/14/72 10:13 P.M.</p>                                                                                                                                                                                                                                               |                                                     |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="font-size: 1.2em;">Baltimore City Hospitals<br/>21224<br/>4940 Eastern Avenue, Baltimore, Md.</p>                                                                                                        |                                           | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institutions residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>906</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>1631 E. 31 Street</u> <u>21218</u></p> |                                                     |
| <p><b>5. SEX</b></p> <p><u>Male</u></p>                                                                                                                                                                                                                                                                                                                                                                  | <p><b>6. RACE</b></p> <p><u>Negro</u></p> | <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/></p> <p><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>                                                                                                                                                            | <p><b>8. DATE OF BIRTH</b></p> <p><u>3/5/21</u></p> |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p><u>Steel Worker</u></p>                                                                                                                                                                                                                                                                     |                                           | <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p> <p><u>Bethlehem Steel</u></p>                                                                                                                                                                                                                                                                                 |                                                     |
| <p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p><u>Maryland</u></p>                                                                                                                                                                                                                                                                                                                           |                                           | <p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p><u>U.S.A.</u></p>                                                                                                                                                                                                                                                                                               |                                                     |
| <p><b>13. FATHER'S NAME</b></p> <p><u>Jim Hicks</u></p>                                                                                                                                                                                                                                                                                                                                                  |                                           | <p><b>14. MOTHER'S MAIDEN NAME</b></p> <p><u>Maggie Gallaway</u></p>                                                                                                                                                                                                                                                                                          |                                                     |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>Yes</u> <u>WWII</u></p>                                                                                                                                                                                                                                                     |                                           | <p><b>16. SOCIAL SECURITY NO.</b></p> <p><u>219-03-6315</u></p>                                                                                                                                                                                                                                                                                               |                                                     |
| <p><b>17. INFORMANT</b></p> <p><u>Records: BCH-4940 Eastern Avenue</u></p>                                                                                                                                                                                                                                                                                                                               |                                           | <p><b>ADDRESS</b></p> <p><u>21224</u></p>                                                                                                                                                                                                                                                                                                                     |                                                     |
| <p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p><u>Acute Myelogenous Leukemia</u></p>                                                                                                                                              |                                           | <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>                                                                                                                                                                                                                                                                                                    |                                                     |
| <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>                                                                                                                                                                                                                                                         |                                           | <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>                                                                                                                                                                                                                                        |                                                     |
| <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>                                                                                                                                                                                                                                                           |                                           |                                                                                                                                                                                                                                                                                                                                                               |                                                     |
| <p><b>19A. DATE OF OPERATION</b></p> <p><u>2/1</u></p>                                                                                                                                                                                                                                                                                                                                                   |                                           | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>                                                                                                                                                                                                                                                                                                |                                                     |
| <p><b>20A. AUTOPSY?</b> (Yes or No)</p> <p><u>Yes</u></p>                                                                                                                                                                                                                                                                                                                                                |                                           | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>                                                                                                                                                                                                                                                                            |                                                     |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p> <p><input type="checkbox"/></p>                                                                                                                                                                                                                                                                      |                                           | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                                                                                                                                                                                                        |                                                     |
| <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                                                                                   |                                           | <p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p> <p>(APPROX.)</p>                                                                                                                                                                                                                                                                                |                                                     |
| <p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                                                                                                                                                                                              |                                           | <p><b>21F. HOW DID INJURY OCCUR?</b></p>                                                                                                                                                                                                                                                                                                                      |                                                     |
| <p><b>22. I certify that (this hospital) attended the deceased from</b> <u>8/6</u> <u>1972</u> <b>to</b> <u>9/14</u> <u>1972</u></p> <p>that (I) <del>last</del> saw the deceased alive on <u>9/14</u> <u>1972</u> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>not</del> view the body after death.</p> |                                           |                                                                                                                                                                                                                                                                                                                                                               |                                                     |
| <p><b>23A. SIGNATURE</b></p> <p><u>Roland C. Einhorn, MD</u></p>                                                                                                                                                                                                                                                                                                                                         |                                           | <p><b>23B. DATE SIGNED</b></p> <p><u>9/14/72</u></p>                                                                                                                                                                                                                                                                                                          |                                                     |
| <p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p><u>Roland C. Einhorn, MD</u></p>                                                                                                                                                                                                                                                                                                                           |                                           | <p><b>23D. ADDRESS</b></p> <p><u>4940 Eastern Avenue, Baltimore, Md.</u><br/><u>Baltimore City Hospitals</u></p>                                                                                                                                                                                                                                              |                                                     |
| <p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)</p> <p><u>Burial</u></p>                                                                                                                                                                                                                                                                                                                              |                                           | <p><b>24B. DATE</b></p> <p><u>9-19-72</u></p>                                                                                                                                                                                                                                                                                                                 |                                                     |
| <p><b>24C. NAME of CEMETERY or CREMATORY</b></p> <p><u>Baltimore Cemetery</u></p>                                                                                                                                                                                                                                                                                                                        |                                           | <p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p><u>Balto., Md.</u></p>                                                                                                                                                                                                                                                                         |                                                     |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p><u>SEP 18 1972</u></p>                                                                                                                                                                                                                                                                                                                                  |                                           | <p><b>25B. NAME OF REGISTRAR</b></p> <p><u>Wm. C. March</u></p>                                                                                                                                                                                                                                                                                               |                                                     |
| <p><b>25C. FUNERAL DIRECTOR</b></p> <p><u>928 E North Ave.</u></p>                                                                                                                                                                                                                                                                                                                                       |                                           | <p><b>ADDRESS</b></p>                                                                                                                                                                                                                                                                                                                                         |                                                     |

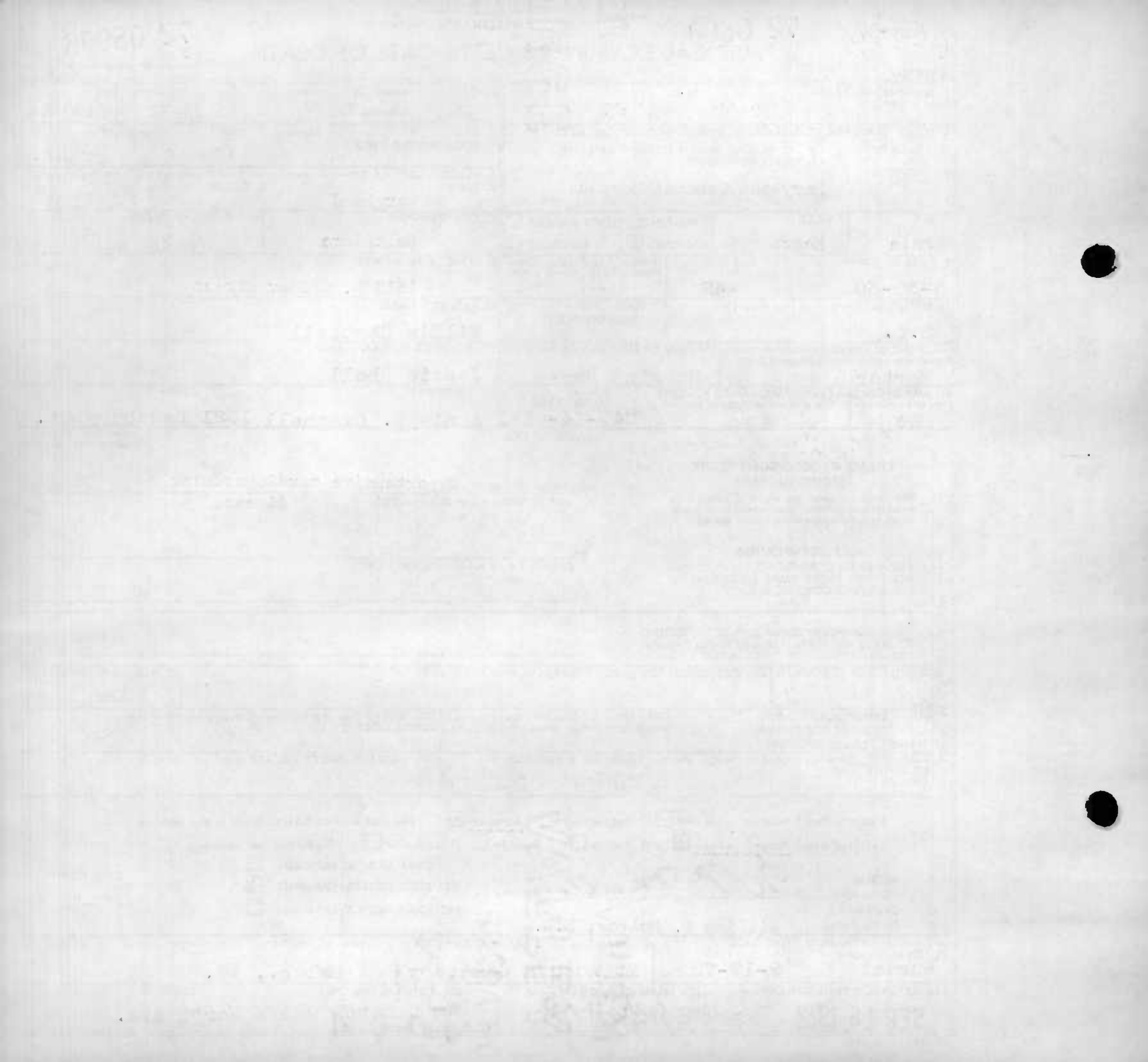


STATE OF MARYLAND-DEM  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. \_\_\_\_\_

BIRTH NO.

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                        |  |                                                                                                                                                             |  |                                                          |  |                                                                                                               |  |                                                                                               |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | L. Freddie Campbell                    |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>                                                            |  | Month<br>9                                               |  | Day<br>15                                                                                                     |  | Year<br>72                                                                                    |  | Hour<br>8:00 A.M.                            |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>Maryland General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                        |  | 3. DATE PRONOUNCED DEAD<br>Month<br>9                                                                                                                       |  |                                                          |  | Day<br>15                                                                                                     |  | Year<br>72                                                                                    |  | Hour<br>8:00 A.M.                            |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                        |  | B. COUNTY<br>1501                                                                                                                                           |  |                                                          |  |                                                                                                               |  |                                                                                               |  |                                              |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7. RACE<br>Negro                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | C. CITY OR TOWN<br>Baltimore                             |  |                                                                                                               |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 9. DATE OF BIRTH<br>5-30-30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10. AGE (In years last birthday)<br>42 |  | 11. BIRTHPLACE (State or foreign country)<br>S.C.                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?                             |  | E. STREET AND NUMBER<br>1618 N. Gilmore Street                                                                |  |                                                                                               |  |                                              |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Porter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                        |  | 15. MOTHER'S MAIDEN NAME<br>Jessie Shell                                                                                                                    |  |                                                          |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No |  |                                                                                               |  |                                              |  |
| 17. SOCIAL SECURITY NO.<br>247-44-6181                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                        |  | 18. INFORMANT<br>Annie R. Campbell                                                                                                                          |  |                                                          |  | ADDRESS<br>1621 Bakebury Ct.                                                                                  |  |                                                                                               |  |                                              |  |
| 19. CAUSE OF DEATH<br>412.2<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Hypertensive cardiovascular disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                 |  |                                        |  |                                                                                                                                                             |  |                                                          |  |                                                                                                               |  |                                                                                               |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 20A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                          |  |                                                                                                               |  |                                                                                               |  | 21. AUTOPSY? (Yes or No)<br>Yes              |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                        |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  |                                                          |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                      |  |                                                                                               |  |                                              |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                        |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                   |  |                                                          |  | 22F. HOW DID INJURY OCCUR?                                                                                    |  |                                                                                               |  |                                              |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: W.P. Mulloy M.D.<br>EXAMINER'S NAME (Type): William P. Mulloy, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED: 9-15-72 |  |                                        |  |                                                                                                                                                             |  |                                                          |  |                                                                                                               |  |                                                                                               |  |                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                        |  | 24B. DATE<br>9-19-72                                                                                                                                        |  | 24C. NAME OF CEMETERY or CREMATORY<br>Mt Auburn Cemetery |  |                                                                                                               |  | 24D. LOCATION (City, town, or county) (State)<br>Balto., Md.                                  |  |                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                        |  | 25B. NAME OF REGISTRAR<br>A. J. H. H. H.                                                                                                                    |  |                                                          |  | 25C. FUNERAL DIRECTOR ADDRESS<br>Wm C March 928 E North Ave.                                                  |  |                                                                                               |  |                                              |  |

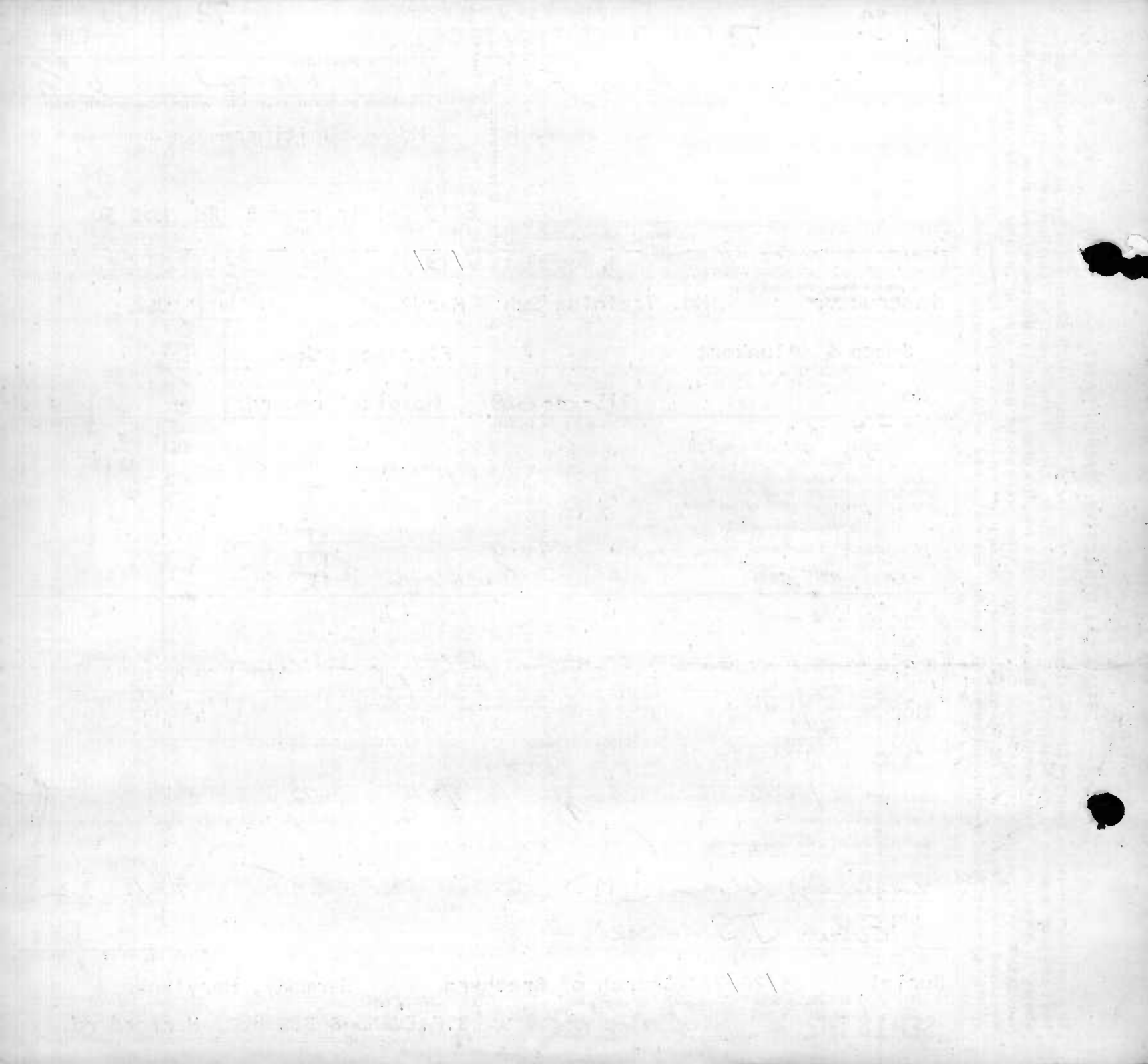


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                         |                             |                                                                                                                                                             |                                    |                                                                                                                                       |                              |                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------|--|
| P-452                                                                                                                                                                                                                                                                                                                                                   |                             | 72 08909                                                                                                                                                    |                                    | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                      |                              | 72 08909                                                                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                               |                             | 1. NAME OF DECEASED<br>(Type or Print) <i>PLUNKERT, ALLEN F.</i>                                                                                            |                                    | 2. DATE AND HOUR OF DEATH<br><i>9-16-72</i> <i>6 A.M.</i>                                                                             |                              | REG. NO.                                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> |                              |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>37 Mercy</i>                                                                                                                                                                                                                                                                                                 |                             |                                                                                                                                                             |                                    | C. CITY OR TOWN                                                                                                                       |                              | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                         |                             |                                                                                                                                                             |                                    | E. STREET AND NUMBER<br><i>8219 Belair road B. Rd. Lot 30</i>                                                                         |                              |                                                                                               |  |
| 5. SEX<br><i>MALE</i>                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><i>CAUCASIAN</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>7/19/14</i> | 9. AGE (In years last birthday)<br><i>58</i>                                                                                          | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.                                                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>instructor</i>                                                                                                                                                                                                                                        |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Md. Training Sch</i>                                                                                                |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                                                                          |                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                    |  |
| 13. FATHER'S NAME<br><i>James S Plunkert</i>                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Florence Baker</i>                                                                                     |                              |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                                                   |                             | 16. SOCIAL SECURITY NO.<br><i>215-20-8529</i>                                                                                                               |                                    | 17. INFORMANT<br><i>Hospital records</i>                                                                                              |                              | ADDRESS                                                                                       |  |
| 18. <i>157.9</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                         |                             |                                                                                                                                                             |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |                              |                                                                                               |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                          |                             |                                                                                                                                                             |                                    | (A) IMMEDIATE CAUSE <i>MYOCARDIAL ISCHEMIA</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                                     |                              |                                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                          |                             |                                                                                                                                                             |                                    | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><i>PANCREATIC CA</i>                                                                           |                              |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                  |                             |                                                                                                                                                             |                                    |                                                                                                                                       |                              |                                                                                               |  |
| 19A. DATE OF OPERATION<br><i>9-7-72</i>                                                                                                                                                                                                                                                                                                                 |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)<br><i>NO</i>                                                                                                |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                       |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                           |                              |                                                                                               |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                            |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                                                                            |                              |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/20</i> 19 <i>72</i> to <i>9/16</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>9/16</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |                                                                                                                                                             |                                    |                                                                                                                                       |                              |                                                                                               |  |
| 23A. SIGNATURE<br><i>Eugene J. Strasser MD</i>                                                                                                                                                                                                                                                                                                          |                             |                                                                                                                                                             |                                    | 23B. DATE SIGNED<br><i>9-16-72</i>                                                                                                    |                              |                                                                                               |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>EUGENE J. STRASSER</i>                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             |                                    | 23D. ADDRESS                                                                                                                          |                              |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                               |                             | 24B. DATE<br><i>9/20/72</i>                                                                                                                                 |                                    | 24C. NAME of CEMETERY or CREMATORY<br><i>Church of Brethern</i>                                                                       |                              | 24D. LOCATION (City, town, or county) (State)<br><i>Harmony, Maryland</i>                     |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 18 1972</i>                                                                                                                                                                                                                                                                                                   |                             | 25B. NAME OF REGISTRAR<br><i>Lidney</i>                                                                                                                     |                                    | 25C. FUNERAL DIRECTOR<br><i>C.F. EVANS &amp; SON</i>                                                                                  |                              | ADDRESS<br><i>8802 Harford rd.</i>                                                            |  |







1

7-432 72 08910 STATE OF MARYLAND - DEPARTMENT OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08910 REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) Terry L. Foltz                                                                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 9 13 72 M.                                       |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>00 527 N. Luzerne                                                                                                                                                                                                                      |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 13 72 9:30 a. M.                                                                                                     |  |
| 6. SEX male                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7. RACE White                                                                                                                                                            |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                      |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 702                                                      |  |
| 9. DATE OF BIRTH 1/21/54                                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years last birthday) 18                                                                                                                                      |  |
| 11. BIRTHPLACE (State or foreign country) Md.                                                                                                                                                                                                                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY? -                                                                                                                                           |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none                                                                                                                                                                                                                                                                                                              |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                        |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no                                                                                                                                                                                                                                                                                                    |  | 17. SOCIAL SECURITY NO. 214-02-8747                                                                                                                                      |  |
| 18. INFORMANT Clayton Reynolds (step-father) same address                                                                                                                                                                                                                                                                                                                                                     |  | ADDRESS                                                                                                                                                                  |  |
| 19. 304.9 I                                                                                                                                                                                                                                                                                                                                                                                                   |  | CAUSE OF DEATH                                                                                                                                                           |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                |  | Intravenous narcotism                                                                                                                                                    |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                      |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |  |
| 20A. DATE OF OPERATION 0                                                                                                                                                                                                                                                                                                                                                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                 |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |  | 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                          |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        |  | 22F. HOW DID INJURY OCCUR?                                                                                                                                               |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                          |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) Peter Lipkovic, M.D.                                                                                                                                                                                                                                                                                                                                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                               |  | 24B. DATE 9/18/72                                                                                                                                                        |  |
| 24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery                                                                                                                                                                                                                                                                                                                                                   |  | 24D. LOCATION (City, town, or county) (State) Balto. Md.                                                                                                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 18 1972                                                                                                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR Sidney Whiston                                                                                                                                    |  |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213                                                                                                                                                                                                                                                                                                                        |  | ADDRESS                                                                                                                                                                  |  |

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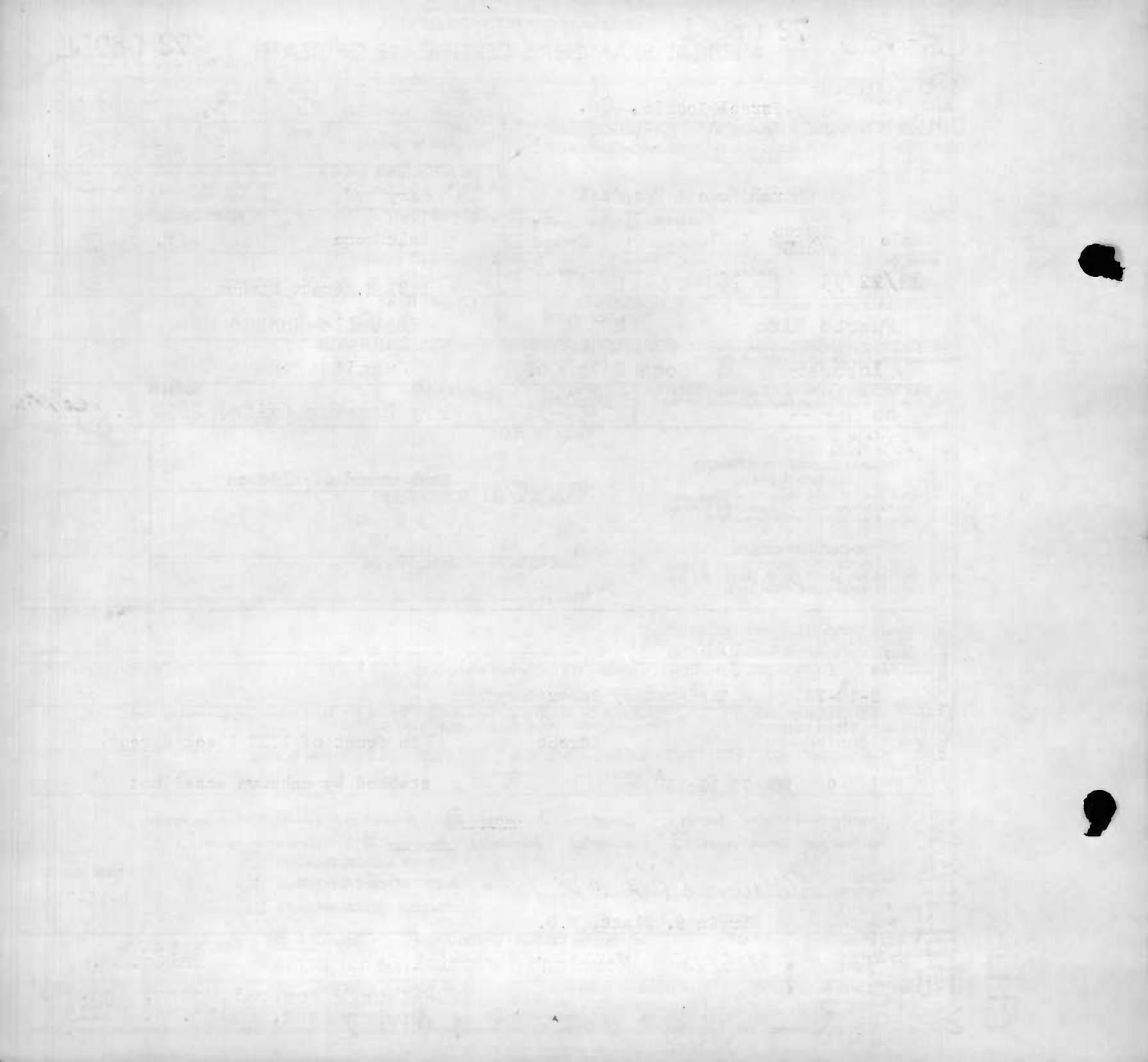
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| STATE OF MARYLAND - DEPT. OF HEALTH<br>BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                               |  |                                                                                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                               |  |                                                                                                              |  |
| REG. NO. 72 08911                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                               |  |                                                                                                              |  |
| BIRTH NO. R-230 72 08911                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                               |  |                                                                                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print) Israel Rosado, Sr.                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 9 13, 72 1:40P. M. |                                                                                                               |  |                                                                                                              |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>35 Church Home & Hospital                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 13 72 1:40 P. M.                                                                  |                                                                                                               |  |                                                                                                              |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 201                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |                                                                                                                                       |                                                                                                               |  |                                                                                                              |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br>Puerto Rican                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                       | C. CITY OR TOWN<br>Baltimore                                                                                  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |  |
| 9. DATE OF BIRTH<br>11/22/35                                                                                                                                                                                                                                                                                                                                                                                  |  | 10. AGE (in years lost birthday)<br>36                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. BIRTHPLACE (State or foreign country)<br>Puerto Rico                                                                                                    |                                                                                                                                       | 12. CITIZEN OF<br>USA                                                                                         |  | E. STREET AND NUMBER<br>1922 E. Pratt Street                                                                 |  |
| 13. FATHER'S NAME<br>Isabello Rosado                                                                                                                                                                                                                                                                                                                                                                          |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>laborer                                                                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>Juanita Pena                                                                                                                    |                                                                                                                                       | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service)<br>no |  | 17. SOCIAL SECURITY NO.<br>82-52-9774                                                                        |  |
| 18. INFORMANT<br>Mary Rosardo (wife)                                                                                                                                                                                                                                                                                                                                                                          |  | 19. CAUSE OF DEATH<br>E 966X1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | 20. DATE OF OPERATION<br>3 9-10-72                                                                                                                          |                                                                                                                                       | 21. AUTOPSY? (Yes or No)<br>Yes                                                                               |  | 22. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>203 in front of 1722 Fleet Street |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 24. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 25. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                               |                                                                                                                                       | 26. NAME OF REGISTRAR<br>Marvin S. Platt, M.D.                                                                |  | 27. FUNERAL DIRECTOR<br>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213                     |  |
| 28. DATE<br>9/16/72                                                                                                                                                                                                                                                                                                                                                                                           |  | 29. NAME OF CEMETERY or CREMATORY<br>Moreland Memorial Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 30. LOCATION (City, town, or county) (State)<br>Balto. Md.                                                                                                  |                                                                                                                                       | 31. CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                           |  | 32. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                           |  |
| 33. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                       |  | 34. DATE SIGNED<br>9-14-72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 35. SIGNATURE<br>Marvin S. Platt, M.D.                                                                                                                      |                                                                                                                                       | 36. SIGNATURE<br>Marvin S. Platt, M.D.                                                                        |  | 37. SIGNATURE<br>Marvin S. Platt, M.D.                                                                       |  |



72 08912

STATE OF MARYLAND - DEPT  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08912

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>RICHARD C. REID</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 2. DATE OF DEATH<br>Known <b>Sept</b> Month <b>11</b> , Day <b>1972</b> Year <b>1972</b> Hour <b>M.</b><br>Estimated <input type="checkbox"/>    |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST. AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 3. DATE PRONOUNCED DEAD<br>Month <b>September</b> Day <b>11</b> Year <b>1972</b> Hour <b>6:50 P.</b> M.                                          |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2864</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                  |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. RACE<br><b>White</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>June 29, 1911</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 10. AGE (In years last birthday) <b>61</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                             |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       |  |
| 13. FATHER'S NAME<br><b>Richard C. Reid</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cashier, Md. Racing Comm</b>                    |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Bessie Delano</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES WWII</b>                       |  |
| 17. SOCIAL SECURITY NO.<br><b>215-07-8527</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 18. INFORMANT ADDRESS<br><b>W. Wallace Reid 524 Overbrook Rd.</b>                                                                                |  |
| 19. CAUSE OF DEATH<br><b>188X I Renal Failure</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Hydronephrosis</b><br><b>Carcinoma of bladder</b>                                                                                                                                                                                                                                                                                         |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                     |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                  |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                        |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/12/72</b> |                         |                                                                                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 24B. DATE<br><b>9/14/72</b>                                                                                                                      |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Dulaney Valley Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Timonium, Md.</b>                                                                            |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><b>Sidney H. Hester</b>                                                                                                |  |
| 25C. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | ADDRESS<br><b>6500 York Rd.</b>                                                                                                                  |  |

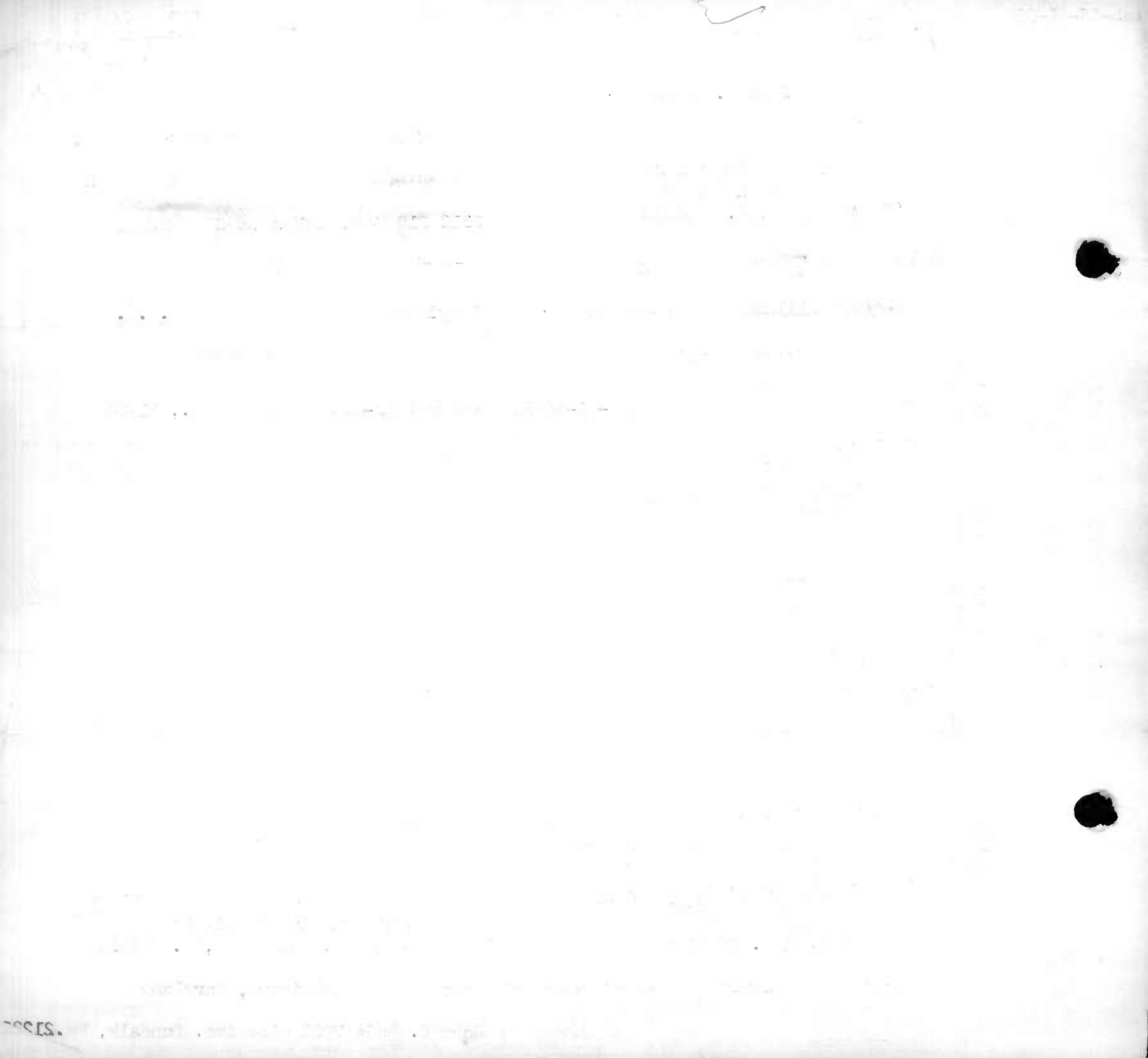
9-25-1972 - Correction Form from Funeral Director-Mitchell-Wiedefeld Home (per J.J. Quinn)  
5400 York Road, Balto., Md. 21212 - HRS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                          |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                            |  | REG. NO.                                                                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| H-553                                                                                                                                                                                              |  | 72 08913                                                                                                    |  | 72 08913                                                                                                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                             |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                      |  | 2. DATE AND HOUR OF DEATH                                                                                                                                |  |
| John F. Amend Sr.                                                                                                                                                                                  |  |                                                                                                             |  | 9/13/72 5:30 A.M.                                                                                                                                        |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE 8. COUNTY |  |                                                                                                                                                          |  |
| Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Md. 21224                                                                                                                            |  | Maryland Baltimore                                                                                          |  |                                                                                                                                                          |  |
| 5. SEX                                                                                                                                                                                             |  | 6. RACE                                                                                                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                               |  |
| Male                                                                                                                                                                                               |  | Caucasian                                                                                                   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                           |  | 8. DATE OF BIRTH                                                                                                                                         |  |
| Retired Millhand                                                                                                                                                                                   |  | Nelson Box Co.                                                                                              |  | 5-28-05                                                                                                                                                  |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                          |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                |  | 9. AGE (In years last birthday)                                                                                                                          |  |
| Maryland                                                                                                                                                                                           |  | U.S.A.                                                                                                      |  | 67                                                                                                                                                       |  |
| 13. FATHER'S NAME                                                                                                                                                                                  |  | 14. MOTHER'S MAIDEN NAME                                                                                    |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                |  |
| Conrad Amend                                                                                                                                                                                       |  | Eva Brehm                                                                                                   |  | Maryland                                                                                                                                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)                                                                                        |  | 16. SOCIAL SECURITY NO.                                                                                     |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |
| No                                                                                                                                                                                                 |  | 216-01-4635A                                                                                                |  | Records: BCH-4940 Eastern Ave., 21224                                                                                                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) |  | CAUSE OF DEATH                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |
| 227.21 + 571.0                                                                                                                                                                                     |  | bilateral subdural hygromas                                                                                 |  | 1 month                                                                                                                                                  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                         |  |                                                                                                                                                          |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                         |  |                                                                                                                                                          |  |
| II                                                                                                                                                                                                 |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                         |  |                                                                                                                                                          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                   |  | chronic alcoholism, Laennec's cirrhosis                                                                     |  |                                                                                                                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                            |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                |  |
| 28/15/72                                                                                                                                                                                           |  | bilateral subdural hygromas                                                                                 |  | YES                                                                                                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                 |  |
|                                                                                                                                                                                                    |  |                                                                                                             |  |                                                                                                                                                          |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                      |  | 21E. INJURY OCCURRED                                                                                        |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |
|                                                                                                                                                                                                    |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                           |  |                                                                                                                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8/10 to 9/13 19 72                                                                                                               |  | that (I) (we) last saw the deceased alive on 9/13 19 72                                                     |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |
| 23A. SIGNATURE                                                                                                                                                                                     |  | 23B. DATE SIGNED                                                                                            |  |                                                                                                                                                          |  |
| Herbert G. Markley M.D.                                                                                                                                                                            |  | 9/13/72                                                                                                     |  |                                                                                                                                                          |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                       |  | 23D. ADDRESS                                                                                                |  |                                                                                                                                                          |  |
| Herbert G. Markley                                                                                                                                                                                 |  | Baltimore City Hospitals<br>4940 Eastern Ave., Baltimore, Md. 21224                                         |  |                                                                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                           |  | 24B. DATE                                                                                                   |  | 24C. NAME OF CEMETERY or CREMATORY                                                                                                                       |  |
| Burial                                                                                                                                                                                             |  | 9-16-72                                                                                                     |  | Sacred Heart of Jesus                                                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR                                                                                      |  | 25C. FUNERAL DIRECTOR                                                                                                                                    |  |
| SEP 18 1972                                                                                                                                                                                        |  | John J. Duda                                                                                                |  | 7922 Wise Ave. Dundalk, Md. 21222                                                                                                                        |  |





| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                      |  |                                                                                                                                                             |                                                                                                                                                                |                                               |                                                                             |                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                      |  |                                                                                                                                                             |                                                                                                                                                                |                                               |                                                                             |                                                                                               |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                      |  |                                                                                                                                                             | REG. NO.                                                                                                                                                       |                                               |                                                                             |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Robert B. Hueg</b><br><b>Bob Heug</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                      |  |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month <b>9</b> Day <b>12</b> Year <b>72</b> Hour <b>M.</b> |                                               |                                                                             |                                                                                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 Union Memorial Hospital</b>                                                                                                                                                                                                      |  |                                                                                                                      |  |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month <b>9</b> Day <b>12</b> Year <b>72</b> Hour <b>9:50 p.</b>                                                                     |                                               |                                                                             |                                                                                               |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>101</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                      |  |                                                                                                                                                             |                                                                                                                                                                |                                               |                                                                             |                                                                                               |  |
| 6. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 7. RACE<br><b>White</b>                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                                | C. CITY OR TOWN<br><b>Balto.</b>              |                                                                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>5-12-53</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (In years last birthday)<br><b>19</b>                                                                        |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                |                                                                                                                                                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |                                                                             | E. STREET AND NUMBER<br><b>3135 Elliott Street</b>                                            |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                      |  |                                                                                                                                                             | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                              |                                               |                                                                             |                                                                                               |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                      |  |                                                                                                                                                             | 17. SOCIAL SECURITY NO.<br><b>216-26-0126</b>                                                                                                                  |                                               | 18. INFORMANT <b>Mother:</b> ADDRESS <b>21224</b>                           |                                                                                               |  |
| 19. <b>E 922.71</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                      |  |                                                                                                                                                             | CAUSE OF DEATH<br><b>Gunshot wound of chest</b>                                                                                                                |                                               |                                                                             |                                                                                               |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                |  |                                                                                                                      |  |                                                                                                                                                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                         |                                               |                                                                             |                                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  |                                                                                                                      |  |                                                                                                                                                             | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                            |                                               |                                                                             |                                                                                               |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  |                                                                                                                      |  |                                                                                                                                                             | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                            |                                               |                                                                             |                                                                                               |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                     |  |                                                                                                                                                             |                                                                                                                                                                |                                               |                                                                             |                                                                                               |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.<br><input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING                                                                                                                                                                                                                                                    |  | 22B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)<br><b>Apartment</b>         |  |                                                                                                                                                             | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>2233 St. Paul Street</b>                                                        |                                               |                                                                             |                                                                                               |  |
| 22D. TIME OF INJURY (APPROX.)<br><b>9 12 72</b>                                                                                                                                                                                                                                                                                                                                                               |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  |                                                                                                                                                             | 22F. HOW DID INJURY OCCUR?<br><b>Subject was shot accidentally</b>                                                                                             |                                               |                                                                             |                                                                                               |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                      |  |                                                                                                                                                             |                                                                                                                                                                |                                               |                                                                             |                                                                                               |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Peter Lipkovic, M.D.</b>                                                                                                                                                                                                                                                                                                                                     |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                      |  |                                                                                                                                                             | DATE SIGNED<br><b>9/13/72</b>                                                                                                                                  |                                               |                                                                             |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>9-16-72</b>                                                                                          |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Carmel Cemetery</b>                                                                                            |                                                                                                                                                                |                                               | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Audrey H. Horton</b>                                                                    |  |                                                                                                                                                             | 25C. FUNERAL DIRECTOR ADDRESS<br><b>John J. Duda 2829 Hudson St. Balto. Md. 21224</b>                                                                          |                                               |                                                                             |                                                                                               |  |

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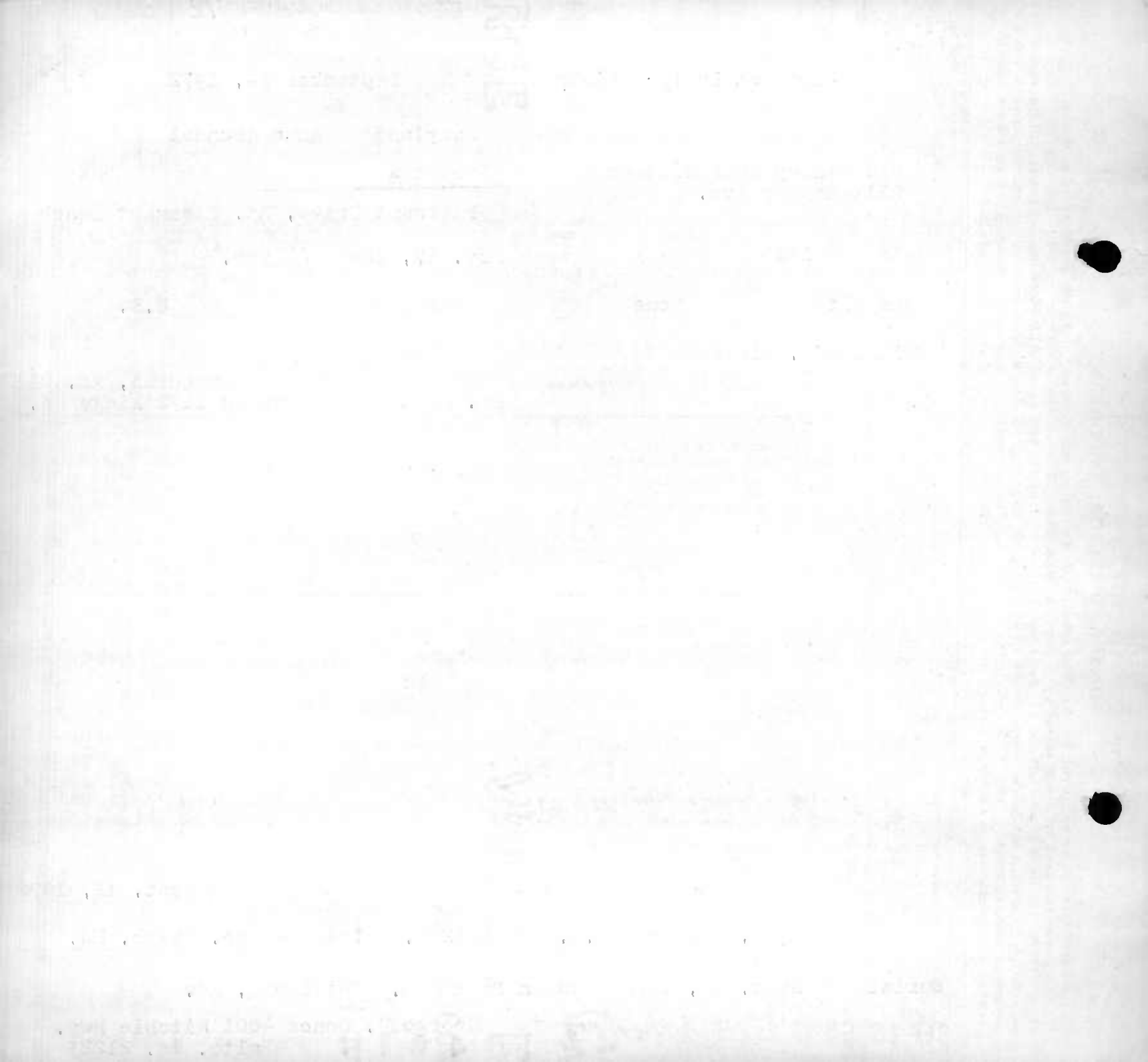
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

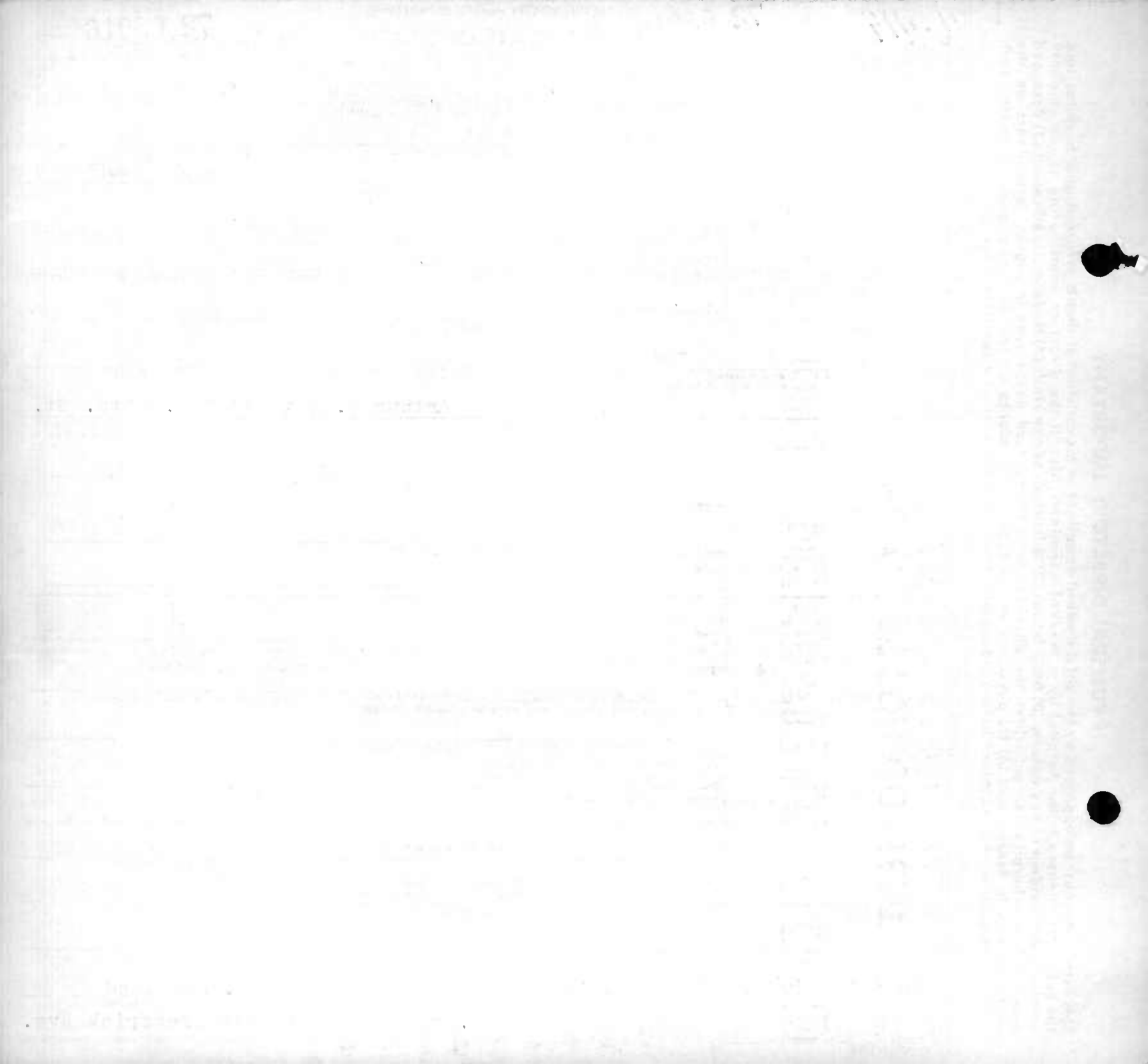
|                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                         |  | 72 08915                                                                                                                                                                                                                                                                                                                                               |  | 72 08915                                                                                                                                                    |  |
| BIRTH NO. <b>K-610</b>                                                                                                                                                                                                                                   |  | 72 08915                                                                                                                                                                                                                                                                                                                                               |  | REG. NO. <b>72 08915</b>                                                                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                   |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                                                                                                                                                              |  | STATE OF MARYLAND-DEMI                                                                                                                                      |  |
| <b>Florence Evelyn Kirby</b>                                                                                                                                                                                                                             |  | <b>September 14, 1972</b>                                                                                                                                                                                                                                                                                                                              |  | <b>5:20 P. M.</b>                                                                                                                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                                                                                                                                                                                                                                                                  |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>90 The Wesley Methodist Home</b><br><b>2211 Rogers Ave.</b>                                                                                                                                                   |  | A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                             |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                     |  | C. CITY OR TOWN<br><b>Pasadena</b>                                                                                                                                                                                                                                                                                                                     |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                               |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                  |  | 6. RACE<br><b>White</b>                                                                                                                                                                                                                                                                                                                                |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                          |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                                                                                                                                                                                                                                                                                       |  | 8. DATE OF BIRTH<br><b>Nov. 17, 1888</b>                                                                                                                    |  |
| 13. FATHER'S NAME<br><b>William J. Biggs</b>                                                                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>Ellen</b>                                                                                                                                                                                                                                                                                                               |  | 9. AGE (In years lost birthday)<br><b>84 yrs.</b>                                                                                                           |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                    |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                |  | 17. INFORMANT<br><b>Mr. Matthias Hieatzman</b>                                                                                                              |  |
| 18. <b>412.31</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral vascular accident</b> |  | 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Arteriosclerotic heart disease</b>                                                                                                                                                                            |  | 20. DATE OF BIRTH<br><b>Nov. 17, 1888</b>                                                                                                                   |  |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>II</b>                                                                                                        |  | 22. I certify that (I) (this hospital) attended the deceased from <b>7 September 1972</b> to <b>14 September 1972</b> , that (I) (we) last saw the deceased alive on <b>14 September 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 23. DATE SIGNED<br><b>Sept. 15, 1972</b>                                                                                                                    |  |
| 24. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                 |  | 25. DATE<br><b>Sept. 18, 1972</b>                                                                                                                                                                                                                                                                                                                      |  | 26. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cem.</b>                                                                                                |  |
| 27. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                     |  | 28. NAME OF REGISTRAR<br><b>Sidney W. Barnaby</b>                                                                                                                                                                                                                                                                                                      |  | 29. FUNERAL DIRECTOR<br><b>George J. Gonce</b>                                                                                                              |  |
| 30. ADDRESS<br><b>Balto. Md. 21225</b>                                                                                                                                                                                                                   |  | 31. ADDRESS<br><b>Balto. Md. 21225</b>                                                                                                                                                                                                                                                                                                                 |  | 32. ADDRESS<br><b>Balto. Md. 21225</b>                                                                                                                      |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| 11-414                                                                                                                                                                                                                                                                                                                     |  | 72 08916                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |  | REG. NO. 72 08916                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | STATE OF MARYLAND - DEATH                                                                                                                                   |  |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mabel R. Uhl/Felder.</i>                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><i>9-11-72 8 A.M.</i>                                                                                                          |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                     |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>2002</i>                           |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>34</i><br><i>BON Secours Hospital</i>                                                                                                                                                                                                                                           |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                      |  | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                         |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX<br><i>F</i>                                                                                                                                                                                                                                                                                                         |  | 6. RACE<br><i>W</i>                                                                                       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>05-23-85</i>                                                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired.</i>                                                                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>HOUSEWIFE</i>                                                     |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                                                                                                |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                    |  |
| 13. FATHER'S NAME<br><i>BENJAMIN RUTH</i>                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><i>Lydia ROGERSON</i>                                                                                                           |  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                      |  | 16. SOCIAL SECURITY NO.<br><i>217-54-4134</i>                                                             |  | 17. INFORMANT<br><i>Arthur A. Ruth 2120 W. Balto. St.</i>                                                                                                   |  |                                                                                               |  |
| 18. <i>412.41</i><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                                               |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>Cardiac failure, Arrhythmia.</i>                                                                                      |  |                                                                                                           |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                         |  |                                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>ASCVD.</i>                                                                                                                                                                            |  |                                                                                                           |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |  |                                                                                               |  |
| (C)                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                     |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                               |  |
| 19A. DATE OF OPERATION<br><i>9-11-72</i>                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br><i>NO</i>                                                                                                                      |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-5-72</i> to <i>9-11-72</i> , that (I) (we) last saw the deceased alive on <i>9-11-72</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                               |  |
| 23A. SIGNATURE<br><i>Bhargava</i>                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 23B. DATE SIGNED<br><i>9-11-72</i>                                                                                                                          |  | 23C. PHYSICIAN'S NAME (Type)<br><i>Bhargava</i>                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                  |  | 24B. DATE<br><i>9/14/1972</i>                                                                             |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Loudon Park</i>                                                                                                    |  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 18 1972</i>                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR<br><i>Lidny</i>                                                                    |  | 25C. FUNERAL DIRECTOR<br><i>G. Truman Schwab 3512 Frederick Ave.</i>                                                                                        |  |                                                                                               |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                |  |                                                                                                        |                                                                                                                                                                                        | REG. NO. 72 08917                                                        | STATE OF MARYLAND - DEMO |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------|
| P-620<br>BIRTH NO.                                                                                                                                                                                                                                                                                                              |  | 72 08917                                                                                               |                                                                                                                                                                                        | CERTIFICATE OF DEATH                                                     |                          |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 2. DATE AND HOUR OF DEATH                                                                                                                                                              |                                                                          |                          |
| PRICE ETHEL M                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        | SEPTEMBER 12, 1972 4:52 P.                                                                                                                                                             |                                                                          |                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                          |  |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)                                                                                                   |                                                                          |                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>40 ST AGNES HOSPITAL                                                                                                                                                                                                                                                                    |  |                                                                                                        | A. STATE<br>MARYLAND<br>B. COUNTY<br>QA 6700                                                                                                                                           |                                                                          |                          |
| 5. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                |  |                                                                                                        | 6. RACE<br>WHITE                                                                                                                                                                       |                                                                          |                          |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                     |  |                                                                                                        | 8. DATE OF BIRTH<br>04 14 99 73                                                                                                                                                        |                                                                          |                          |
| 9. AGE (In years last birthday)                                                                                                                                                                                                                                                                                                 |  |                                                                                                        | 10. BIRTHPLACE (State or foreign country)                                                                                                                                              |                                                                          |                          |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                       |  |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                           |                                                                          |                          |
| 13. FATHER'S NAME<br>HARRY T MARSH                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 14. MOTHER'S MAIDEN NAME<br>BESSIE OREM                                                                                                                                                |                                                                          |                          |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                     |  |                                                                                                        | 16. SOCIAL SECURITY NO.<br>218032074                                                                                                                                                   |                                                                          |                          |
| 17. INFORMANT<br>BALTIMORE MD 21229                                                                                                                                                                                                                                                                                             |  |                                                                                                        | ADDRESS<br>ST AGNES RECORDS WILKENS & CATON AVES                                                                                                                                       |                                                                          |                          |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                               |  |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                           |                                                                          |                          |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                              |  |                                                                                                        | (A) IMMEDIATE CAUSE<br>Coronary occlusion<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Cardiovascular disease<br>(B) DUE TO, OR AS A CONSEQUENCE OF: atherosclerosis<br>(C) Diabetes Mellitus |                                                                          |                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                          |  |                                                                                                        |                                                                                                                                                                                        |                                                                          |                          |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No)                                                |                          |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                                                                                                                                                        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                          |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                       |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                                                                        | 21F. HOW DID INJURY OCCUR?                                               |                          |
| 22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 7 19 72 to SEPTEMBER 12 19 72, that (X) (we) last saw the deceased alive on SEPTEMBER 12 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (We) (did) (XXXX) view the body after death. |  |                                                                                                        |                                                                                                                                                                                        |                                                                          |                          |
| 23A. SIGNATURE<br>Fereydoun Schwab                                                                                                                                                                                                                                                                                              |  |                                                                                                        |                                                                                                                                                                                        | 23B. DATE SIGNED<br>9-12-72                                              |                          |
| 23C. PHYSICIAN'S NAME (Type)<br>DR. FEREYDOUN MD                                                                                                                                                                                                                                                                                |  |                                                                                                        |                                                                                                                                                                                        | 23D. ADDRESS<br>ST AGNES HOSPITAL<br>WILKENS & CATON AVES BALTO MD 21229 |                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                              |  | 24B. DATE<br>9/16/1972                                                                                 |                                                                                                                                                                                        | 24C. NAME OF CEMETERY or CREMATORY<br>Loudon Park                        |                          |
| 24D. LOCATION<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                            |  | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                         |                                                                                                                                                                                        | 25B. NAME OF REGISTRAR<br>Sidney Whitton                                 |                          |
| 25C. FUNERAL DIRECTOR<br>G. Truman Schwab                                                                                                                                                                                                                                                                                       |  | 25D. ADDRESS<br>3512 Frederick Ave.                                                                    |                                                                                                                                                                                        | 25E. DATE<br>9-1-73                                                      |                          |







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |                                                                                                                                                                                          |                                                                             |                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| N-400<br>BIRTH NO. 72-03752 72 08918                                                                                                                                                                                                                                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                               |                                                                                                                                                                                          | REG. NO. 72 08918                                                           |                                                                                    |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Noel, Jennifer</i>                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 2. DATE AND HOUR OF DEATH<br><i>9-13-72 1151 P.M.</i>                                                                                                                                    |                                                                             |                                                                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                |  |                                                                                                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>605</i>                                                        |                                                                             |                                                                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>33 Johns Hopkins Hospo</i>                                                                                                                                                                                                                                                                                 |  |                                                                                                        | C. CITY OR TOWN<br><i>Buttimore</i>                                                                                                                                                      |                                                                             | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <i>F</i> 6. RACE <i>N</i>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                 |                                                                             | 8. DATE OF BIRTH<br><i>2-23-72</i>                                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                           |  |                                                                                                        | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                        |                                                                             | 9. AGE (In years last birthday)<br><i>6:21</i>                                     |
| 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                                                               |                                                                             |                                                                                    |
| 13. FATHER'S NAME<br><i>Robert Noel</i>                                                                                                                                                                                                                                                                                                               |  |                                                                                                        | 14. MOTHER'S MAIDEN NAME<br><i>Katie Stevens</i>                                                                                                                                         |                                                                             |                                                                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                              |  |                                                                                                        | 16. SOCIAL SECURITY NO.                                                                                                                                                                  |                                                                             | 17. INFORMANT<br><i>parents</i>                                                    |
| 18. <i>42201</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.     |  |                                                                                                        | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>asphyxiation</i><br>(B) <i>asphyxiation</i> DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <i>chronic heart failure</i> |                                                                             |                                                                                    |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><i>sophocoric</i>                                                                                                                                                                                           |  |                                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                             |                                                                             |                                                                                    |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                                                                                                                                          | 20A. AUTOPSY? (Yes or No)                                                   |                                                                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                 |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                                                                                                                                                          | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |                                                                                    |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                             |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                                                                                                                                                          | 21F. HOW DID INJURY OCCUR?                                                  |                                                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10 September 1972</i> to <i>14 September 1972</i> that (I) (we) last saw the deceased alive on <i>14 September 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |                                                                                                                                                                                          |                                                                             |                                                                                    |
| 23A. SIGNATURE<br><i>Neil H. Senzer</i>                                                                                                                                                                                                                                                                                                               |  |                                                                                                        | 23B. DATE SIGNED<br><i>9/14/72</i>                                                                                                                                                       |                                                                             | 23C. ADDRESS<br><i>Box #9 Johns Hopkins Hospital</i>                               |
| 23A. PHYSICIAN'S NAME (Type)<br><i>NEIL H. SENZER, M.D.</i>                                                                                                                                                                                                                                                                                           |  |                                                                                                        | 23B. ADDRESS<br><i>Box #9 Johns Hopkins Hospital</i>                                                                                                                                     |                                                                             |                                                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><i>9/14/72</i>                                                                            |                                                                                                                                                                                          | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary</i>                    |                                                                                    |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                                                                         |  | 24E. DATE REC'D BY HEALTH DEPT.<br><i>SEP 18 1972</i>                                                  |                                                                                                                                                                                          | 24F. NAME OF REGISTRAR<br><i>Joseph G. Rock</i>                             |                                                                                    |
| 24G. FUNERAL DIRECTOR<br><i>Joseph G. Rock</i>                                                                                                                                                                                                                                                                                                        |  | 24H. ADDRESS<br><i>13041 Central Ave</i>                                                               |                                                                                                                                                                                          | 24I. DATE REC'D BY HEALTH DEPT.<br><i>SEP 18 1972</i>                       |                                                                                    |

2

1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the progress of the work.

2. The second part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

3. The third part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

4. The fourth part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

5. The fifth part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

6. The sixth part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

7. The seventh part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

8. The eighth part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

9. The ninth part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

10. The tenth part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a general idea of the progress of the work.

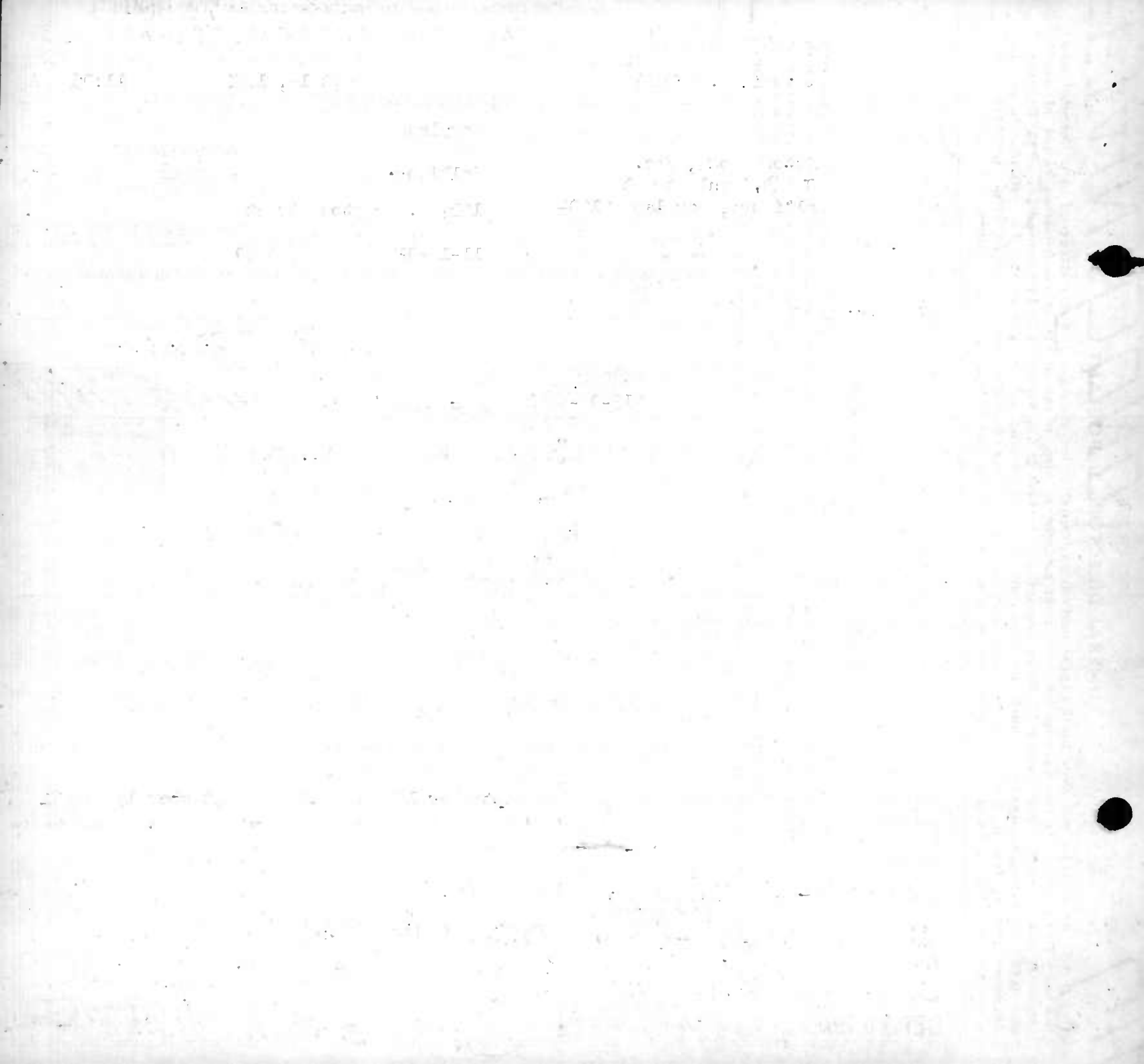
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| T-520                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 72 08919                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                 |  | 72 08919                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 72 08919                                                                                                  |  | CERTIFICATE OF DEATH                                                                                                                             |  | REG. NO.                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Annie E. THOMAS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><b>Sept 15, 1972 11:05 A.M.</b>                                                                                     |  |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Midtown Home, Inc.<br/>808 St. Paul Street<br/>Baltimore, Maryland 21202</b>                                                                                                                                                                                                                                               |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1001</b>       |  |                                                                      |  |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. RACE <b>B</b>                                                                                          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>11-17-01</b>                                     |  |
| 9. AGE (In years last birthday) <b>70</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10. AGE (In years last birthday) <b>70</b>                                                                |  | 11. BIRTHPLACE (State or foreign country) <b>Pa.</b>                                                                                             |  | 12. CITIZEN OF WHAT COUNTRY?                                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                |  |                                                                      |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME <b>Annie Johnson</b>                                                                                                    |  |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 16. SOCIAL SECURITY NO. <b>213-07-5661</b>                                                                                                       |  | 17. INFORMANT <b>Dorcas Walker 419 N. Wolfe St.</b>                  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio-Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Congestive Heart Failure</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Hypertensive heart disease</b><br><b>Sclerosis</b> |  |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                     |  |                                                                      |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)                                                                                                                        |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                         |  |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                       |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>September 1, 1972</b> to <b>September 15, 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept 15, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                      |  |
| 23A. SIGNATURE <b>William D. Applefeld M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 23B. DATE SIGNED                                                                                                                                 |  | 23C. PHYSICIAN'S NAME (Type) <b>William D. Applefeld M.D.</b>        |  |
| 23D. ADDRESS <b>6615 Reisterstown Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 23E. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 24B. DATE <b>9/18/72</b>                                                                                  |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Int. Calvary</b>                                                                                           |  | 24D. LOCATION (City, town, or county) <b>Baltimore</b>               |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25B. NAME OF REGISTRAR <b>Andrew Ingerson</b>                                                             |  | 25C. FUNERAL DIRECTOR <b>Joseph B. Rock</b>                                                                                                      |  | 25D. ADDRESS <b>1304 N. Central</b>                                  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | 72 08920                                                                                                                | 72 08920 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | REG. NO.                                                                                                                |          |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | 2. DATE AND HOUR OF DEATH                                                                                               |          |  |
| James Palmer Wales                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | Sept. 13, 1972                                                                                                          |          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                   |          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>42 SINAI Hosp.                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | A. STATE<br>Md.                                                                                                         |          |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | B. COUNTY<br>2831                                                                                                       |          |  |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 6. RACE<br>White                                                                                                        |          |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                            |  |                                                                                                        |  | 8. DATE OF BIRTH<br>Aug. 16, 1890                                                                                       |          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Salesman                                                                                                                                                                                                                                                |  |                                                                                                        |  | 9. AGE (In years last birthday)<br>82                                                                                   |          |  |
| 10B. KIND OF BUSINESS OR INDUSTRY<br>Insurance                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                   |          |  |
| 13. FATHER'S NAME<br>James                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                     |          |  |
| 14. MOTHER'S MAIDEN NAME<br>Wales                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>yes WW 1 |          |  |
| 16. SOCIAL SECURITY NO.<br>212 10 4035                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  | 17. INFORMANT<br>Grace Capizzi 8612 Dovedale Rd Randallston                                                             |          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Coronary occlusion                                                                                                                               |  |                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden                                                                  |          |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                         |  |                                                                                                        |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Periarteritis nodosa                                          |          |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | 15 years                                                                                                                |          |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                         |          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                         |          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No)<br>No                                                                                         |          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                             |          |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                              |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                              |          |  |
| 22. I certify that (I) <del>(XXXXXX)</del> attended the deceased from 19 50 to 19 72, that (I) <del>(we)</del> last saw the deceased alive on August 18, 19 72 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(XXXX)</del> (did) <del>(not)</del> view the body after death. |  |                                                                                                        |  |                                                                                                                         |          |  |
| 23A. SIGNATURE<br>Millard T. Traband, Jr. M.D.                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | 23B. DATE SIGNED<br>9/15/72                                                                                             |          |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Millard T. Traband, Jr. M.D.                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 23D. ADDRESS<br>1811 N. Rolling Rd. Woodlawn Md. 21207                                                                  |          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>burial                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br>9-16-72                                                                                   |  | 24C. NAME of CEMETERY or CREMATORY<br>Lorraine Park                                                                     |          |  |
| 24D. LOCATION<br>Woodlawn, Md. 21207                                                                                                                                                                                                                                                                                                                   |  | 24E. NAME of CEMETERY or CREMATORY<br>Lorraine Park                                                    |  | 24F. LOCATION<br>Woodlawn, Md. 21207                                                                                    |          |  |
| 25A. DATE REC'D. BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR<br>Sidney Johnston                                                              |  | 25C. FUNERAL DIRECTOR<br>John I. Stansbury 6411 Windsor Mill Rd.                                                        |          |  |

9214 1426

CL 7,000 TRD C. 05

BRIDGE

CL 4 10000 TRD C. 05

TRANSMISSION

CL 4 10000 TRD C. 05

BRIDGE

CL 4 10000 TRD C. 05

CL 4 10000 TRD C. 05

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Willie Johnson</b>                                                                                                                                                                                                                                                                 |  | 2. DATE AND HOUR OF DEATH<br><b>9-13-72 5:20 P.M.</b>                                                                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>Bon Secour Hospital</b>                                                                                                                                                                                                                                         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>City</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Bon Secour Hospital</b>                                                                                                                                                                                      |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 5. SEX <b>M</b> 6. RACE <b>B</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                    |  | 8. DATE OF BIRTH <b>10-9-14</b> 9. AGE (in years last birthday) <b>57 yrs</b>                                                           |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unemployed</b>                                                                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>I</b>                                                                                              |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>South Carolina</b>                                                                                                                                                                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>America</b>                                                                                          |  |
| 13. FATHER'S NAME<br><b>Walter Johnson</b>                                                                                                                                                                                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME<br><b>Eliza Cokeband</b>                                                                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                        |  | 16. SOCIAL SECURITY NO.<br><b>247-26-4873</b>                                                                                           |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                |  | ADDRESS                                                                                                                                 |  |
| 18. <b>250.41</b> CAUSE OF DEATH                                                                                                                                                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                            |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CHRONIC RENAL FAILURE</b>                                                                                               |  | <b>YRS</b>                                                                                                                              |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>DIABETIC NEPHROPATHY</b>                                                                                                                                                                |  | <b>YRS</b>                                                                                                                              |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                       |  |                                                                                                                                         |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                        |  |
| 20A. AUTOPSY? (Yes or No) <b>No</b>                                                                                                                                                                                                                                                                                          |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                               |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                     |  |                                                                                                                                         |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                         |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/7/1972</b> to <b>9/13/1972</b> that (I) (we) last saw the deceased alive on <b>9/13/1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                         |  |
| 23A. SIGNATURE<br><b>Chaihan</b>                                                                                                                                                                                                                                                                                             |  | 23B. DATE SIGNED<br><b>9/13/72</b>                                                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CHAIHAN UNG BHAKORN M.D.</b>                                                                                                                                                                                                                                                              |  | 23D. ADDRESS<br><b>BON SECOURS HOSP.</b>                                                                                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Removal</b>                                                                                                                                                                                                                                                                   |  | 24B. DATE<br><b>9-16-72</b>                                                                                                             |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Sumter</b>                                                                                                                                                                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State)<br><b>South Carolina</b>                                                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR<br><b>Dr. J. L. Brown</b>                                                                                        |  |
| 25C. FUNERAL DIRECTOR<br><b>I. L. Brown &amp; Son</b>                                                                                                                                                                                                                                                                        |  | ADDRESS<br><b>123-W. Montgomery S</b>                                                                                                   |  |



OLD PAPER BOOK BOUND





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                 |  |                                                                                          |  | 72 08922                                                                                                                                                    |  | 72 08922                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                             |  |                                                                                          |  | REG. NO.                                                                                                                                                    |  |                                                                                       |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                           |  | 2. DATE AND HOUR OF DEATH                                                                |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
| A-652<br>ARRINGTON, Walter                                                                                                                                                                                                                                                                                                       |  | 9/15/72 6:25 P.M.                                                                        |  | Lutheran Hospital<br>BALTIMORE, Md. 21216                                                                                                                   |  | MARYLAND<br>1607                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                           |  | 6. RACE                                                                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH                                                                      |  |
| M                                                                                                                                                                                                                                                                                                                                |  | B                                                                                        |  |                                                                                                                                                             |  | 6-16-17                                                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                      |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY?                                                          |  |
|                                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | VIRGINIA                                                                                                                                                    |  | U.S.                                                                                  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                |  |                                                                                          |  | 14. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                                                                       |  |
| Walter Arrington                                                                                                                                                                                                                                                                                                                 |  |                                                                                          |  | Rosie Sparrows                                                                                                                                              |  |                                                                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                         |  | 16. SOCIAL SECURITY NO.                                                                  |  | 17. INFORMANT                                                                                                                                               |  | 18. ADDRESS                                                                           |  |
| no                                                                                                                                                                                                                                                                                                                               |  | 160183344                                                                                |  | LINDA A. EDWARDS (DAUGHTER)                                                                                                                                 |  | 1341 N. STRICKER ST.                                                                  |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                               |  |                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                                       |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                                                                                          |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Acute Cardiorespiratory Arrest<br>5 min.                                                          |  |                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | (B) Subarachnoid haemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF:<br>6 days                                                                                   |  |                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | (C)                                                                                                                                                         |  |                                                                                       |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                           |  |                                                                                          |  |                                                                                                                                                             |  |                                                                                       |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                           |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |
|                                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | NO                                                                                                                                                          |  |                                                                                       |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  |                                                                                                                                                             |  |                                                                                       |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                    |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                                                                                             |  |                                                                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/9/1972 to 9/15/1972 that (I) (we) last saw the deceased alive on 9/15/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                          |  |                                                                                          |  |                                                                                                                                                             |  |                                                                                       |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | 23B. DATE SIGNED                                                                                                                                            |  |                                                                                       |  |
| m. Dongre                                                                                                                                                                                                                                                                                                                        |  |                                                                                          |  |                                                                                                                                                             |  |                                                                                       |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                     |  | 23D. ADDRESS                                                                             |  |                                                                                                                                                             |  |                                                                                       |  |
| DR. S.S. DONGRE                                                                                                                                                                                                                                                                                                                  |  | LUTHERAN HOSPITAL OF M.D.<br>730, ASHBURTON ST. BALTO.-MD. 21216                         |  |                                                                                                                                                             |  |                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                         |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State)                                         |  |
| Burial                                                                                                                                                                                                                                                                                                                           |  | 9-20-72                                                                                  |  | Mt. Auburn Cem.                                                                                                                                             |  | Balto., Md.                                                                           |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                  |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                                                                                       |  | ADDRESS                                                                               |  |
| SEP 18 1972                                                                                                                                                                                                                                                                                                                      |  | Audrey [illegible]                                                                       |  | V. Bailey                                                                                                                                                   |  | 1348 N. Calhoun Street                                                                |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                             |                                 |                                                                                                                                                                                                                                                                                                              |                                          |                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------------------|--|
| B-652                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 72 08923                                                                                                                                                    |                                 | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                             |                                          | 72 08923                                                                                 |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 72 08923                                                                                                                                                    |                                 | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                         |                                          | REG. NO.                                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Francis X. Burns, SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                 | 2. DATE AND HOUR OF DEATH<br><b>9/15/72 5:55 P.M.</b>                                                                                                                                                                                                                                                        |                                          |                                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Mercy Hospital</b>                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                             |                                 | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>C. CITY OR TOWN <b>Baltimore</b><br>E. STREET AND NUMBER <b>7848 Gough Street #21224.</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                          |                                                                                          |  |
| 5. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>7/10/21</b> | 9. AGE (In years last birthday) <b>51</b>                                                                                                                                                                                                                                                                    | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min.                                                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Industrial Buyer</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>CROWN, CORK &amp; SEAL</b>                                                                                          |                                 | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, MD.</b>                                                                                                                                                                                                                                           |                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                               |  |
| 13. FATHER'S NAME<br><b>EDWARD P. BURNS, SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                             |                                 | 14. MOTHER'S MAIDEN NAME<br><b>CATHERINE HASCHERT</b>                                                                                                                                                                                                                                                        |                                          |                                                                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES W. W. II</b>                                                                                                                                                                                                                                                                                                                                                                                           |                      | 16. SOCIAL SECURITY NO.<br><b>220-05-0552</b>                                                                                                               |                                 | 17. INFORMANT<br><b>MARY E. BURNS</b> ADDRESS <b>7848 GOUGH ST. BALTO., 21224, MD.</b>                                                                                                                                                                                                                       |                                          |                                                                                          |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>320.9 I Meningoencephalitis - Brain Abscess</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(A) IMMEDIATE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                      |                                                                                                                                                             |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>                                                                                                                                                                                                                                                |                                          |                                                                                          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                             |                                 |                                                                                                                                                                                                                                                                                                              |                                          |                                                                                          |  |
| 19A. DATE OF OPERATION<br><b>Sept 15, 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Brain Abscess</b>                                                                                    |                                 | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                                                                                                                                                                                                                       |                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                     |                                          |                                                                                          |  |
| 21D. TIME OF INJURY (APPROX.)<br><b>Sept 15, 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                           |                                 | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                   |                                          |                                                                                          |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>Sept 10</b> 19 <b>72</b> to <b>Sept 15</b> 19 <b>72</b> , that (1) we last saw the deceased alive on <b>Sept 15</b> 19 <b>72</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                                                                                                                                                       |                      |                                                                                                                                                             |                                 |                                                                                                                                                                                                                                                                                                              |                                          |                                                                                          |  |
| 23A. SIGNATURE<br><b>Richard A. Pratt MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      |                                                                                                                                                             |                                 | 23B. DATE SIGNED<br><b>Sept 15 72</b>                                                                                                                                                                                                                                                                        |                                          | 23C. PHYSICIAN'S NAME (Type)<br><b>Richard A. Pratt</b>                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 24B. DATE<br><b>9-19-72</b>                                                                                                                                 |                                 | 24C. NAME OF CEMETERY or CREMATORY<br><b>NEW CATHEDRAL CEM.</b>                                                                                                                                                                                                                                              |                                          | 24D. LOCATION (City, town, or county) (State)<br><b>4300 OLD FREDERICK RD. BALTO. MD</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 25B. NAME OF REGISTRAR<br><b>Charles J. Geller</b>                                                                                                          |                                 | 25C. FUNERAL DIRECTOR<br><b>901 S. CONKLING ST. BALTO., 21224, MD.</b>                                                                                                                                                                                                                                       |                                          |                                                                                          |  |

Handwritten text, mostly illegible due to blurriness and bleed-through. Visible fragments include:  
"MAY 1904"  
"THE WHITE"  
"CROWNED GUY"  
"EDWARD P. BURNS, SR."  
"W. W. II"  
"CHURCH HAD CHECK"  
"1748 GUY"  
"BROWN ALBINO"

Handwritten text at the bottom of the page, including:  
"JAN 12 1904"  
"MAY 1904"  
"BURNED 9-12-1904"  
"BURNED 9-12-1904"

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| K-4601                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      | BALTIMORE CITY HEALTH DEPARTMENT<br>72 08924<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                     |                                 | REG. NO. 72 08924                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>HARRY V. KELLER (HARRY V. KELLER)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 2. DATE AND HOUR OF DEATH<br><b>9/15/72 6AM</b>                                                                                                                                                                                                                                                                                                          |                                 |                                                                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Dukeland Nursing Home<br/>1501 Dukeland Street.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>Loch Raven LA Hospital 1901</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1602 W. Baltimore Street, 21223.</b> |                                 |                                                                                       |
| 5. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                      | 8. DATE OF BIRTH <b>2/14/94</b> | 9. AGE (In years last birthday) <b>78</b>                                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN ICE CO.</b>                                                                                                                                                                                                                                                                                                |                                 | 11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>                          |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 13. FATHER'S NAME <b>unknown KELLER</b>                                                                                                                                                                                                                                                                                                                  |                                 |                                                                                       |
| 14. MOTHER'S MAIDEN NAME <b>unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W. W. I</b>                                                                                                                                                                                                                              |                                 |                                                                                       |
| 16. SOCIAL SECURITY NO. <b>EXP-10-10000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 17. INFORMANT <b>JOS. P. KELLER 1612 Ingram Rd #21239</b>                                                                                                                                                                                                                                                                                                |                                 |                                                                                       |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>SS. 214-01-5189</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>(A) IMMEDIATE CAUSE <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                             |                                 |                                                                                       |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                         |                                 | 20A. AUTOPSY? (Yes or No)                                                             |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                           |                                 |                                                                                       |
| 21B. PLACE OF INJURY (e.g., in or about home, lam., factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                 |                                 |                                                                                       |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                |                                 |                                                                                       |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | 22. I certify that (I) (this hospital) attended the deceased from <b>8-28 1972</b> to <b>9-15 1972</b><br>that (I) (we) last saw the deceased alive on <b>9-15 1972</b> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.                         |                                 |                                                                                       |
| 23A. SIGNATURE<br><b>Thomas W. Harris, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      | 23B. DATE SIGNED<br><b>9-15-72</b>                                                                                                                                                                                                                                                                                                                       |                                 | 23C. PHYSICIAN'S NAME (Type)<br><b>THOMAS W. HARRIS, MD</b>                           |
| 23D. ADDRESS<br><b>4260 EDMONDSON AVE BALTO. MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                |                                 |                                                                                       |
| 24B. DATE<br><b>9-18-72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 24C. NAME of CEMETERY or CREMATORY<br><b>LOUDON PARK CEMETERY</b>                                                                                                                                                                                                                                                                                        |                                 | 24D. LOCATION (City, town, or county) (State)<br><b>3801 FREDERICK AVE. BALTO, MD</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      | 25B. NAME OF REGISTRAR<br><b>Andrew H. ...</b>                                                                                                                                                                                                                                                                                                           |                                 | 25C. FUNERAL DIRECTOR<br><b>Charles J. Spiller</b>                                    |
| 25D. ADDRESS<br><b>901 S. CONKLING ST. BALTO., 21224, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                                                                                                                                                                                                                          |                                 |                                                                                       |

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RESEARCH REPORT

NO. 100

1950

1950

THE UNIVERSITY OF CHICAGO

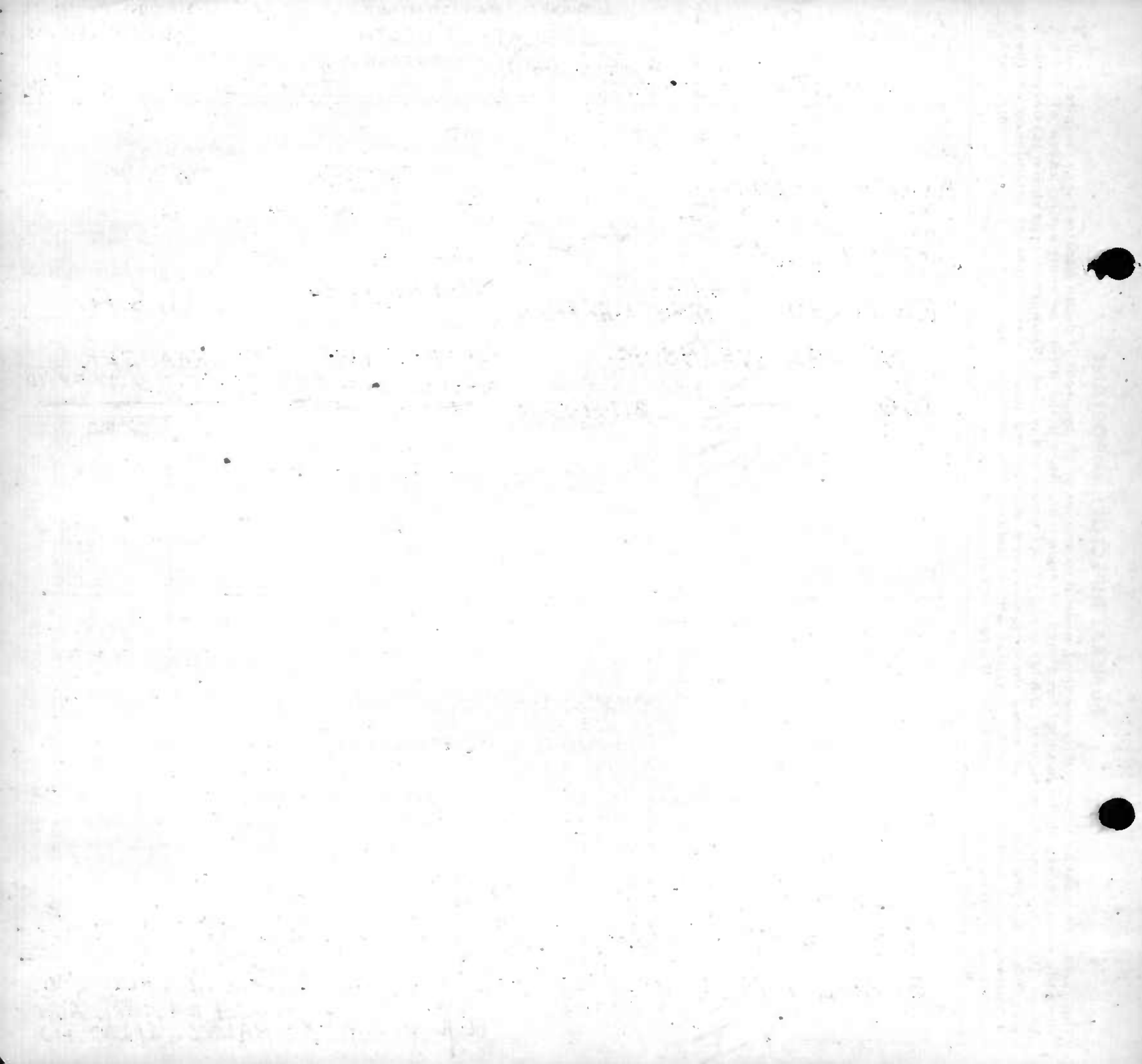
DEPARTMENT OF CHEMISTRY

RESEARCH REPORT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                 |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT |  |  |  | 72 68925                                                                                                                                   |  |  |  | 72 68925 |  |  |  | REG. NO. |  |  |  | STATE OF MARYLAND - DEMO |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------|--|--|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------|--|--|--|----------|--|--|--|--------------------------|--|--|--|
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                                       |  |  |  |                                  |  |  |  | 2. DATE AND HOUR OF DEATH                                                                                                                  |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| HERBERT WERNISING                                                                                                                                                                                                                                                                                         |  |  |  |                                  |  |  |  | 9-14-72 3:25 P.M.                                                                                                                          |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                    |  |  |  |                                  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)                                                      |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                 |  |  |  |                                  |  |  |  | A. STATE B. COUNTY                                                                                                                         |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| HAMILTON NSE CENTER<br>6040 HARFORD RD.                                                                                                                                                                                                                                                                   |  |  |  |                                  |  |  |  | MD.                                                                                                                                        |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 5. SEX                                                                                                                                                                                                                                                                                                    |  |  |  |                                  |  |  |  | 6. RACE                                                                                                                                    |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| MALE                                                                                                                                                                                                                                                                                                      |  |  |  |                                  |  |  |  | WHITE                                                                                                                                      |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                  |  |  |  |                                  |  |  |  | 8. DATE OF BIRTH                                                                                                                           |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  | 12-2-86                                                                                                                                    |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                               |  |  |  |                                  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| RETIRED                                                                                                                                                                                                                                                                                                   |  |  |  |                                  |  |  |  | BANK NIGHT WATCHMAN                                                                                                                        |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                 |  |  |  |                                  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                               |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| BALTIMORE, MD.                                                                                                                                                                                                                                                                                            |  |  |  |                                  |  |  |  | U.S.A.                                                                                                                                     |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                         |  |  |  |                                  |  |  |  | 14. MOTHER'S MAIDEN NAME                                                                                                                   |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| WILLIAM WERNISING                                                                                                                                                                                                                                                                                         |  |  |  |                                  |  |  |  | CATHERINE STRICKHAUSER                                                                                                                     |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                  |  |  |  |                                  |  |  |  | 16. SOCIAL SECURITY NO.                                                                                                                    |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| NO                                                                                                                                                                                                                                                                                                        |  |  |  |                                  |  |  |  | 217-14-5538                                                                                                                                |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                             |  |  |  |                                  |  |  |  | 18. CAUSE OF DEATH                                                                                                                         |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| MARY E. BELL 6926 GOUGH ST. BALTO., MD.                                                                                                                                                                                                                                                                   |  |  |  |                                  |  |  |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                             |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  | (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  | ANTECEDENT CAUSES                                                                                                                          |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                  |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).           |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  | malnutrition                                                                                                                               |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                    |  |  |  |                                  |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                           |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                 |  |  |  |                                  |  |  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                       |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                   |  |  |  |                                  |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                   |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                  |  |  |  |                                  |  |  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
|                                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 21E. INJURY OCCURRED                                                                                                                                                                                                                                                                                      |  |  |  |                                  |  |  |  | 21F. HOW DID INJURY OCCUR?                                                                                                                 |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                         |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8-21 1972 to 9-14 1972, that (I) (we) last saw the deceased alive on 9-14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                            |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 23B. DATE SIGNED                                                                                                                                                                                                                                                                                          |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                              |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| WYMPAR K. WOLFE                                                                                                                                                                                                                                                                                           |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 23D. ADDRESS                                                                                                                                                                                                                                                                                              |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 6801 Belair Rd 21206.                                                                                                                                                                                                                                                                                     |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                  |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| BURIAL                                                                                                                                                                                                                                                                                                    |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 24B. DATE                                                                                                                                                                                                                                                                                                 |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 9-18-72                                                                                                                                                                                                                                                                                                   |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 24C. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                        |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| HOLY REDEEMER CEM.                                                                                                                                                                                                                                                                                        |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 24D. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                             |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 4430 BELAIR RD. BALTO., MD.                                                                                                                                                                                                                                                                               |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 25A. DATE RECD BY HEALTH DEPT.                                                                                                                                                                                                                                                                            |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| SEP 18 1972                                                                                                                                                                                                                                                                                               |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 25B. NAME OF REGISTRAR                                                                                                                                                                                                                                                                                    |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| Charles J. Jailer                                                                                                                                                                                                                                                                                         |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                     |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |
| 6224 EASTERN AVE. BALTO., MD.                                                                                                                                                                                                                                                                             |  |  |  |                                  |  |  |  |                                                                                                                                            |  |  |  |          |  |  |  |          |  |  |  |                          |  |  |  |

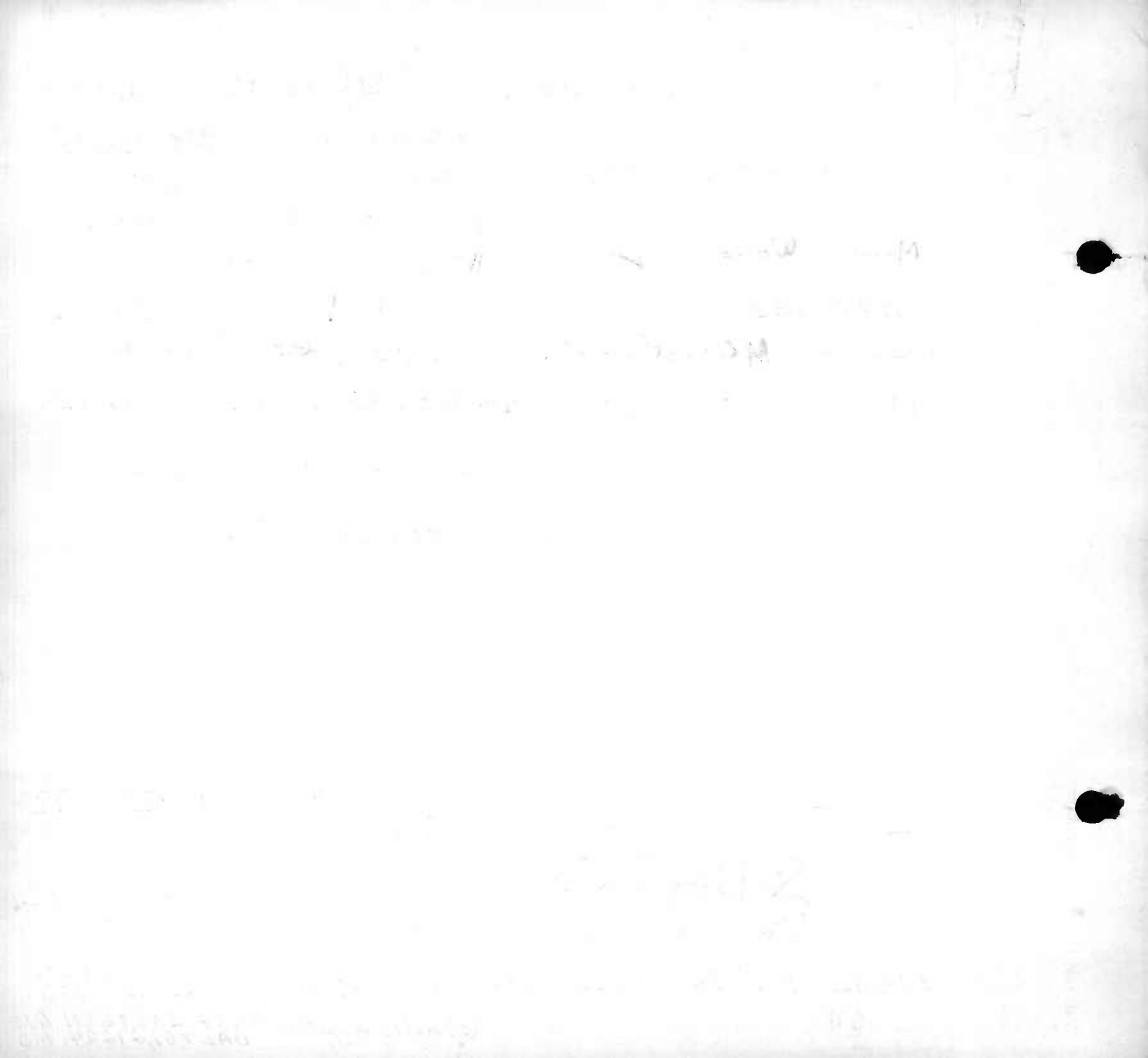




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                                                                                                                                                                                                       |                                    | REG. NO.                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------|
| 72 08926 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                                                                                                                                                                                                                                                       |                                    | STATE OF MARYLAND-DHMH                                                                |
| BIRTH NO. <u>M-244</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 1. NAME OF DECEASED<br>(Type or Print) <u>McClelland, William</u>                                                                                                                                                                                                                                                                     |                                    |                                                                                       |
| 2. DATE AND HOUR OF DEATH<br><u>Sep. 12. 72</u> <u>4:50 P.M.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                |                                    |                                                                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>SOUTH BALTIMORE GEN. HOSP.</u><br><u>43</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Baltimore</u> B. COUNTY <u>Baltimore</u><br>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>537 S 48th St. Balto, Md.</u> |                                    |                                                                                       |
| 5. SEX <u>MALE</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                           | 8. DATE OF BIRTH<br><u>11-3-86</u> | 9. AGE (In years last birthday) <u>86</u><br>If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      | 11. BIRTHPLACE (State or foreign country) <u>Md.</u>                                                                                                                                                                                                                                                                                  |                                    |                                                                                       |
| 13. FATHER'S NAME<br><u>WILLIAM (McCLELLAND)</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 14. MOTHER'S MAIDEN NAME<br><u>LIZA (Earp) EARLE</u>                                                                                                                                                                                                                                                                                  |                                    |                                                                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      | 16. SOCIAL SECURITY NO.<br><u>717-07-7028A</u>                                                                                                                                                                                                                                                                                        |                                    | 17. INFORMANT<br><u>ANDREW McCLELLAND</u><br>ADDRESS<br><u>SAME</u>                   |
| 18. CAUSE OF DEATH<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Bilateral pneumonia</u><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Generalized arteriosclerosis</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No)<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>22. I certify that (I) (this hospital) attended the deceased from <u>8 + 29 19 72</u> to <u>9, 12 19 72</u> that (I) (we) last saw the deceased alive on <u>Sep. 12 19 72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE <u>J. P. Rio, M.D.</u><br>23B. DATE SIGNED <u>Sep. 12. 72</u><br>23C. PHYSICIAN'S NAME (Type) <u>FREWIE Rio</u><br>23D. ADDRESS <u>3001 South Hanover St.</u><br>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u><br>24B. DATE <u>9-15-72</u><br>24C. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u><br>24D. LOCATION (City, town, or county) <u>BA, CO., MD.</u><br>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 18 1972</u><br>25B. NAME OF REGISTRAR <u>Andrew McClelland</u><br>25C. FUNERAL DIRECTOR <u>Charles S. Geiler</u><br>25D. ADDRESS <u>6224 EASTERN AVE. BALTO., MD.</u> |                      |                                                                                                                                                                                                                                                                                                                                       |                                    |                                                                                       |



# FUNERAL DIRECTOR: IMPORTANT

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| Baltimore City Health Department                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | 72 08927 4                                                                            |  | REG. NO.                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| BIRTH NO. <u>11-253</u> <u>72-13791</u>                                                                                                                                                                                                                                                                                           |  |                                                                                          |  | 72 08927 4                                                                            |  |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                            |  |                                                                                          |  | 2. DATE AND HOUR OF DEATH                                                             |  |                                                                      |  |
| MAASKANT, BABY GIRL                                                                                                                                                                                                                                                                                                               |  |                                                                                          |  | SEPTEMBER 15, 1972 8:30A M.                                                           |  |                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                            |  |                                                                                          |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                         |  |                                                                                          |  | A. STATE B. COUNTY                                                                    |  |                                                                      |  |
| 40 ST. AGNES HOSPITAL                                                                                                                                                                                                                                                                                                             |  |                                                                                          |  | MARYLAND 2834                                                                         |  |                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                            |  | 6. RACE                                                                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>            |  | 8. DATE OF BIRTH                                                     |  |
| FEMALE                                                                                                                                                                                                                                                                                                                            |  | CAUCASIAN                                                                                |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 09/15/72                                                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                       |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 11. BIRTHPLACE (State or foreign country)                                             |  | 12. CITIZEN OF WHAT COUNTRY?                                         |  |
| NEW BORN                                                                                                                                                                                                                                                                                                                          |  |                                                                                          |  | MARYLAND                                                                              |  | U.S.A.                                                               |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                 |  |                                                                                          |  | 14. MOTHER'S MAIDEN NAME                                                              |  |                                                                      |  |
| JACK MAASKANT                                                                                                                                                                                                                                                                                                                     |  |                                                                                          |  | RUTH WADDELL MAASKANT                                                                 |  |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                          |  |                                                                                          |  | 16. SOCIAL SECURITY NO.                                                               |  | 17. INFORMANT ADDRESS                                                |  |
|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  |                                                                                       |  | ST. AGNES HOSPITAL RECORDS                                           |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                |  |                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |  |                                                                      |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | 3 minutes                                                                             |  |                                                                      |  |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                |  |                                                                                          |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                 |  |                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |  |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                         |  |                                                                                          |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                   |  |                                                                      |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                               |  |                                                                                          |  |                                                                                       |  |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | NO                                                                                    |  |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  |                                                                                       |  |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                            |  |                                                                      |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                       |  | While At <input type="checkbox"/> At Work <input type="checkbox"/>                       |  |                                                                                       |  |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 15 1972 to SEPTEMBER 15 1972, that (I) (we) last saw the deceased alive on SEPTEMBER 15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                          |  |                                                                                       |  |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                                    |  |                                                                                          |  | 23B. DATE SIGNED                                                                      |  |                                                                      |  |
| AZAD CADER, M.D.                                                                                                                                                                                                                                                                                                                  |  |                                                                                          |  | 9/16/72                                                                               |  |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                      |  |                                                                                          |  | 23D. ADDRESS                                                                          |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | BALTO, MD 21229                                                                       |  |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                          |  | ST. AGNES HOSPITAL; CATON & WILKENS AVE.                                              |  |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                          |  | 24B. DATE                                                                                |  | 24C. NAME OF CEMETERY OR CREMATORY                                                    |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                                            |  | 9/18/72                                                                                  |  | Lorraine Park                                                                         |  | Woodlawn MD                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                 |  | ADDRESS                                                              |  |
| SEP 18 1972                                                                                                                                                                                                                                                                                                                       |  | D. J. W. W. W.                                                                           |  | Wittke Inc                                                                            |  | 1630 E. Edmonson Ave                                                 |  |

WAS SHAWNY RAY DIAL

SEPTEMBER 12, 1972

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| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             |                                                                                                                                                             |  | 72 08928                                                                              |                                              | REG. NO. 72 08928                                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------|--|
| BIRTH NO. 6-431                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                  |                                              |                                                                                            |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GOLDBERG, SAMUEL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>SEPTEMBER 17, 1972 2:15 A.M.</b>                      |                                              |                                                                                            |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) |                                              |                                                                                            |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40 ST AGNES HOSPITAL<br/>CATON &amp; WILKENS AVENUES<br/>BALTIMORE, MARYLAND 21229</b>                                                                                                                                                                                                                                                                                                                                                                                     |                             | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |  | A. STATE <b>MARYLAND</b>                                                              |                                              | B. COUNTY <b>BALTIMORE</b>                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |  | C. CITY OR TOWN <b>BALTIMORE</b>                                                      |                                              | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |  | E. STREET AND NUMBER <b>1703 CHESTERTON ROAD</b>                                      |                                              |                                                                                            |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><b>CAUCASIAN</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/07/94</b>                                                   | 9. AGE (In years last birthday)<br><b>77</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>                                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                          |                                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                              |  |
| 13. FATHER'S NAME<br><b>Bernie BERNARD GOLDBERG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>FANNIE Fisher</b>                                      |                                              |                                                                                            |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                             | 16. SOCIAL SECURITY NO.<br><b>212-22-1399</b>                                                                                                               |  | 17. INFORMANT<br><b>BALTO MD 21229</b>                                                |                                              | ADDRESS<br><b>ST AGNES' RECORDS CATON &amp; WILKENS AVE</b>                                |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b>                                                                                                                                                                                                                                                                                           |                             |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                                              |                                                                                            |  |
| (A) IMMEDIATE CAUSE <i>Liver insuff. coma</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Hepatic coma.</i>                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |  |                                                                                       |                                              |                                                                                            |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF:<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             |  |                                                                                       |                                              |                                                                                            |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             |                                                                                                                                                             |  |                                                                                       |                                              |                                                                                            |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                                                                                                                             |  |                                                                                       |                                              |                                                                                            |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                              |                                                                                            |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |  | 21F. HOW DID INJURY OCCUR?                                                            |                                              |                                                                                            |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 8, 1972</b> to <b>SEPTEMBER 17, 1972</b> , that <input checked="" type="checkbox"/> (myself) last saw the deceased alive on <b>SEPTEMBER 17, 1972</b> and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. |                             |                                                                                                                                                             |  |                                                                                       |                                              |                                                                                            |  |
| 23A. SIGNATURE<br><i>Eduardo G. Romero MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |                                                                                                                                                             |  |                                                                                       |                                              | 23B. DATE SIGNED<br><b>09/17/72</b>                                                        |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>EDUARDO G ROMERO, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             |                                                                                                                                                             |  | 23D. ADDRESS<br><b>BALTO MD 21229<br/>ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>  |                                              |                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             | 24B. DATE<br><b>9/20/72</b>                                                                                                                                 |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>                        |                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Maryland</b>                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             | 25B. NAME OF REGISTRAR<br><i>Edmundson</i>                                                                                                                  |  | 25C. FUNERAL DIRECTOR<br><b>Witzke</b>                                                |                                              | ADDRESS<br><b>1630 EDMONDSON AVENUE 21228</b>                                              |  |

SEPTEMBER 17, 1932

SEPTEMBER 17, 1932

BALTIMORE

ST. ADAM'S HOSPITAL  
CATHOLIC & WILKINS AVENUE  
BALTIMORE, MARYLAND 21201

THE JURY

MALE

MALE

MALE

MALE

MALE

BALTIMORE

ST. ADAM'S HOSPITAL  
CATHOLIC & WILKINS AVENUE

NO

SEPTEMBER 17, 1932

SEPTEMBER 17, 1932

NO

BALTIMORE

ST. ADAM'S HOSPITAL  
CATHOLIC & WILKINS AVENUE

ST. ADAM'S HOSPITAL  
CATHOLIC & WILKINS AVENUE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                                                                                                                                                                                                      |                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | REG. NO. 72 08929                                                                                                                                                                                                                                                                                                                    |                                 |
| G-622 72 08929                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                 |                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GORSUCH CAMILLA MARY</b>                                                                                                                                                                                                                                                                                                                                                                               |                      | 2. DATE AND HOUR OF DEATH<br><b>9 14 72</b> <b>3:03PM.</b>                                                                                                                                                                                                                                                                           |                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST AGNES HOSPITAL<br/>BALTO., MD.</b>                                                                                                                                                                                                                              |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b><br><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br><br>E. STREET AND NUMBER <b>5561 DOLORES AVE.</b> |                                 |
| 5. SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                          | 8. DATE OF BIRTH <b>8 25 05</b> |
| 9. AGE (In years last birthday) <b>67</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                      | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                                                                                                                                                                                                        |                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                                                                                                                                  |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                    |                                 |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                        |                      | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>                                                                                                                                                                                                                                                                                            |                                 |
| 13. FATHER'S NAME <b>JOHN A THIEL</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 14. MOTHER'S MAIDEN NAME <b>MARY ELLEN (TYDINGS)</b>                                                                                                                                                                                                                                                                                 |                                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                                      |                      | 16. SOCIAL SECURITY NO. <b>213 34 1994</b>                                                                                                                                                                                                                                                                                           |                                 |
| 17. INFORMANT ADDRESS <b>21227</b><br><b>Mr. William F. Statton, 5561 Dolores Ave.<br/>ST AGNES HOSP., BALTO., MD.</b>                                                                                                                                                                                                                                                                                                                           |                      |                                                                                                                                                                                                                                                                                                                                      |                                 |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>Renal Failure</b><br><b>Respiratory Failure</b><br><b>Chronic Bronchitis</b> |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                         |                                 |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                                                                                                                                                                                                      |                                 |
| 19A. DATE OF OPERATION <b>9/18/72</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                     |                                 |
| 20A. AUTOPSY? (Yes or No) <b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                 |                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                             |                                 |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                         |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                            |                                 |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                           |                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                           |                                 |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                          |                      |                                                                                                                                                                                                                                                                                                                                      |                                 |
| 23A. SIGNATURE <b>Eitatsu Henzan</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                                     |                                 |
| 23C. PHYSICIAN'S NAME (Type) <b>EITATSU HENZAN</b>                                                                                                                                                                                                                                                                                                                                                                                               |                      | 23D. ADDRESS <b>BALTIMORE, MD 21229</b><br><b>ST. AGNES HOSP. CATON &amp; WILKENS AVES.</b>                                                                                                                                                                                                                                          |                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                           |                      | 24B. DATE <b>9-18-1972</b>                                                                                                                                                                                                                                                                                                           |                                 |
| 24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                 |                      | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                             |                                 |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                                                                                                               |                      | 25B. NAME OF REGISTRAR <b>Sidney Hubbard</b>                                                                                                                                                                                                                                                                                         |                                 |
| 25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 25D. ADDRESS <b>4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                                                                          |                                 |

3:00 PM

0 10 72

PROGAM TITLES

INSTRUMENT

BALTIMORE

ST. ANNE'S HOSPITAL

2221 GOLFERS AVE.

BALTIMORE, MD.

1901 82

8 25 52

WHITE

1 2 1

MARYLAND

NON-EXHAUSTIVE

(TYPING)

JOHN A. THIEL

215 31 1904

NO

WILL TO

BALTIMORE MD 21201

ST. AGNES

10-11-12 New Orleans, Louisiana

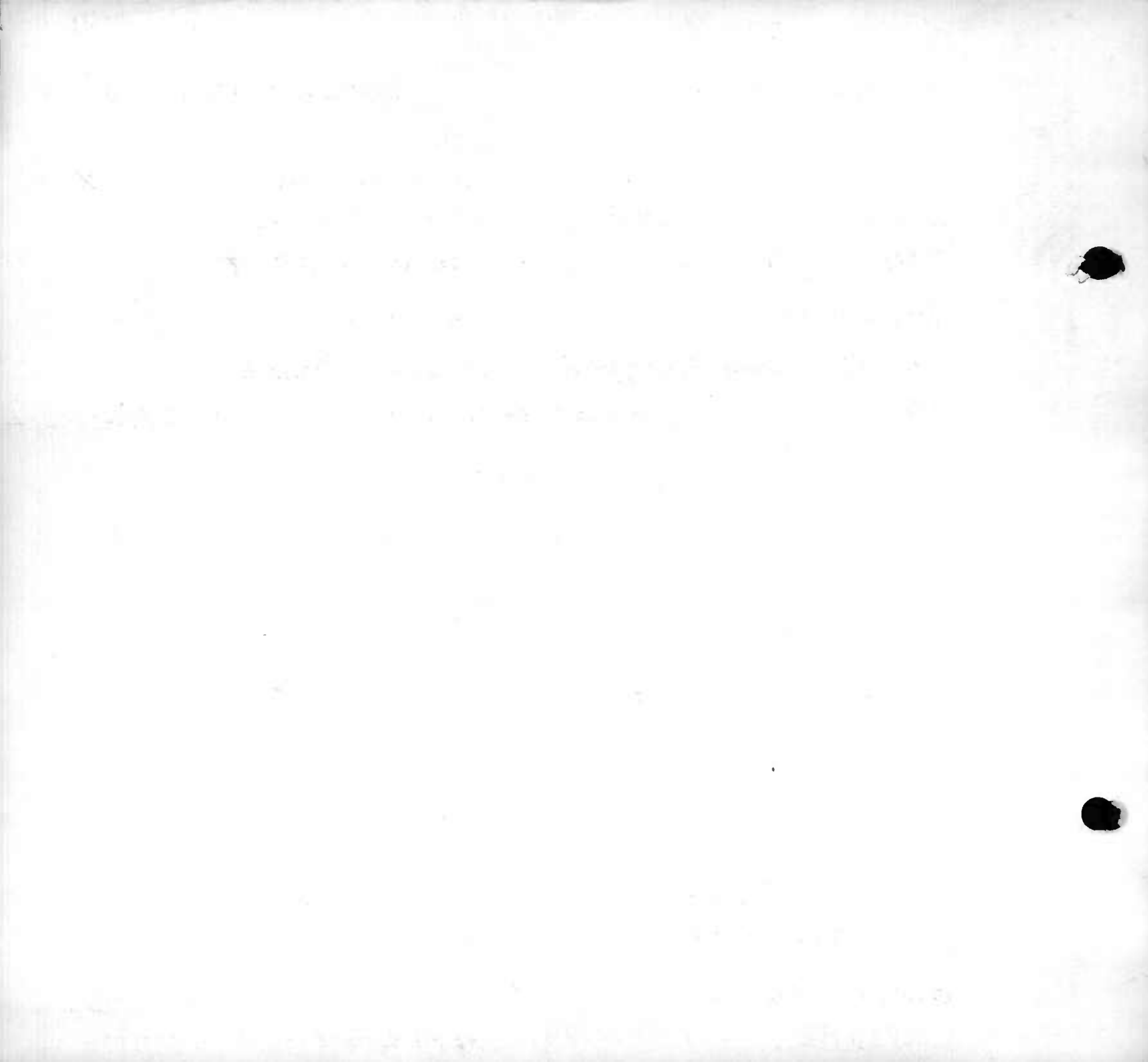
10-11-12



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                          |  |          |  |                                                                                          |  |                                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| G-450                                                                                                                                                                                                                                                                                                    |  | 72 08930 |  | BALTIMORE CITY HEALTH DEPARTMENT                                                         |  | 72 08930                                                                                                                                                    |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                |  |          |  | REG. NO.                                                                                 |  |                                                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                   |  |          |  | 2. DATE AND HOUR OF DEATH                                                                |  |                                                                                                                                                             |  |
| Michael Glenn                                                                                                                                                                                                                                                                                            |  |          |  | 9/14/72 @ 7:45am 8:25 A.M.                                                               |  |                                                                                                                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                   |  |          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)     |  |                                                                                                                                                             |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                             |  |          |  | A. STATE<br>B. COUNTY                                                                    |  |                                                                                                                                                             |  |
| Lutheran Hospital                                                                                                                                                                                                                                                                                        |  |          |  | Md. HOWARD 6300                                                                          |  |                                                                                                                                                             |  |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                         |  |          |  | 6. RACE<br>White                                                                         |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                              |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |  | 8. DATE OF BIRTH                                                                                                                                            |  |
| HOUSEWIFE                                                                                                                                                                                                                                                                                                |  |          |  |                                                                                          |  | 3-26-05 67                                                                                                                                                  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                        |  |          |  | 14. MOTHER'S MAIDEN NAME                                                                 |  | 9. AGE (In years last birthday)                                                                                                                             |  |
| HENRY EISAH FISCHBACH                                                                                                                                                                                                                                                                                    |  |          |  | ADDIE BOHNE                                                                              |  | 67                                                                                                                                                          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                 |  |          |  | 16. SOCIAL SECURITY NO.                                                                  |  | 17. INFORMANT                                                                                                                                               |  |
| NO                                                                                                                                                                                                                                                                                                       |  |          |  | 812-28-9046A                                                                             |  | GEORGE GLENN 9718 HILLSMERE                                                                                                                                 |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                       |  |          |  | 12. CITIZEN OF WHAT COUNTRY?                                                             |  |                                                                                                                                                             |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                           |  |          |  | U.S.A.                                                                                   |  |                                                                                                                                                             |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                             |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                             |  |                                                                                                                                                             |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                        |  |          |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |  |                                                                                                                                                             |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                |  |          |  | Acute Cardiorespiratory Arrest                                                           |  |                                                                                                                                                             |  |
| II                                                                                                                                                                                                                                                                                                       |  |          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |  |                                                                                                                                                             |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                         |  |          |  | Acute myocardial Ischaemia 48 hrs.                                                       |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                    |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                          |  |          |  | 21E. INJURY OCCURRED                                                                     |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| (APPROX.)                                                                                                                                                                                                                                                                                                |  |          |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |                                                                                                                                                             |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12/1972 to 9/14/1972 that (I) (we) lost saw the deceased alive on 9/13/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |          |  |                                                                                          |  |                                                                                                                                                             |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                           |  |          |  | 23B. DATE SIGNED                                                                         |  | 23C. PHYSICIAN'S NAME (Type)                                                                                                                                |  |
| m. Dongre                                                                                                                                                                                                                                                                                                |  |          |  |                                                                                          |  | DR. S. S. DONGRE                                                                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                 |  |          |  | 24B. DATE                                                                                |  | 24C. NAME of CEMETERY or CREMATORY                                                                                                                          |  |
| BURIAL                                                                                                                                                                                                                                                                                                   |  |          |  | 9-18-72                                                                                  |  | LONDON PK. CEM.                                                                                                                                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                          |  |          |  | 25B. NAME of REGISTRAR                                                                   |  | 25C. FUNERAL DIRECTOR                                                                                                                                       |  |
| SEP 18 1972                                                                                                                                                                                                                                                                                              |  |          |  | Arlene Wharton                                                                           |  | WEBER FUNERAL HOME 5311 Edmonson Ave                                                                                                                        |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 08931 BALTIMORE CITY HEALTH DEPARTMENT  
72 08931 CERTIFICATE OF DEATH

REG. NO. 72 08931  
STATE OF MARYLAND-DHMH

|                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                       |                                                                                                                                         |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                       |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>ANNABELLE ANDERSON</b>                                                                                            |                                       | 2. DATE AND HOUR OF DEATH<br><b>9/17/72 12<sup>30</sup> am</b>                                                                          |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>1605</b> |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>44 Union Memorial Hosp</b>                                                                                                                                                                                                                                                           |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                                       | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                     |                                                           |
|                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                       | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                      |                                                           |
|                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                       | E. STREET AND NUMBER<br><b>2525 W. MOSHER STREET</b>                                                                                    |                                                           |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>NEGRO</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>03-22-1909</b> | 9. AGE (In years last birthday) <b>60</b>                                                                                               | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                                 |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>                                                                            |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>AMERICAN</b>                                                                                                                                                                                                                                                                                 |                         | 13. FATHER'S NAME<br><b>ROBERT MARSHALL</b>                                                                                                                 |                                       | 14. MOTHER'S MAIDEN NAME<br><b>LUCY Marshall</b>                                                                                        |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                           |                         | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                       | 17. INFORMANT<br><b>William C. Anderson 2525 W. Mosher St</b>                                                                           |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b>                                                                                                     |                         | 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                          |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                            |                                                           |
| (A) IMMEDIATE CAUSE<br><b>CARDIO RESPIRATORY ARREST</b>                                                                                                                                                                                                                                                                         |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>CARCINOMATOSIS</b>                                                                                                |                                       | 3 months                                                                                                                                |                                                           |
| (C) DUE TO, OR AS A CONSEQUENCE OF:<br><b>CARCINOMA OF STOMACH</b>                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                       | 2 years                                                                                                                                 |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                          |                         |                                                                                                                                                             |                                       |                                                                                                                                         |                                                           |
| 19A. DATE OF OPERATION<br><b>6/21/72</b>                                                                                                                                                                                                                                                                                        |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                       | 20A. AUTOPSY? (Yes or No)                                                                                                               |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                       |                                                                                                                                         |                                                           |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                       |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                       | 21F. HOW DID INJURY OCCUR?                                                                                                              |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/28 1972</b> to <b>9/17 1972</b> , that (I) (we) lost saw the deceased alive on <b>9/16 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                       |                                                                                                                                         |                                                           |
| 23A. SIGNATURE<br><i>Alfonso Guzman</i>                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                       | 23B. DATE SIGNED<br><b>9/17/72</b>                                                                                                      |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ALFONSO GUZMAN, MD</b>                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                       | 23D. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                          |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                        |                         | 24B. DATE<br><b>9/21/72</b>                                                                                                                                 |                                       | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Bethesda Cemetery</b>                                                                          |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>Bethesda City</b>                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                       |                                                                                                                                         |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                           |                         | 25B. NAME OF REGISTRAR<br><i>Sidney Johnson</i>                                                                                                             |                                       | 25C. FUNERAL DIRECTOR<br><i>Alfonso Guzman</i>                                                                                          |                                                           |
| 25D. ADDRESS<br><b>7222 W. North Ave</b>                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                       |                                                                                                                                         |                                                           |

AMERICAN AIRLINES

MEMPHIS

MISSISSIPPI

1000 W. HIGHWAY STREET

MEMPHIS, TENN.

AMERICAN AIRLINES

MEMPHIS, TENN.

MEMPHIS, TENN.

MEMPHIS, TENN.

MEMPHIS, TENN.

MEMPHIS, TENN.

MEMPHIS, TENN.

MEMPHIS, TENN.

MEMPHIS, TENN.

MEMPHIS, TENN.

MEMPHIS, TENN.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08932

BIRTH NO.

STATE OF MARYLAND-DEATH

REG. NO.

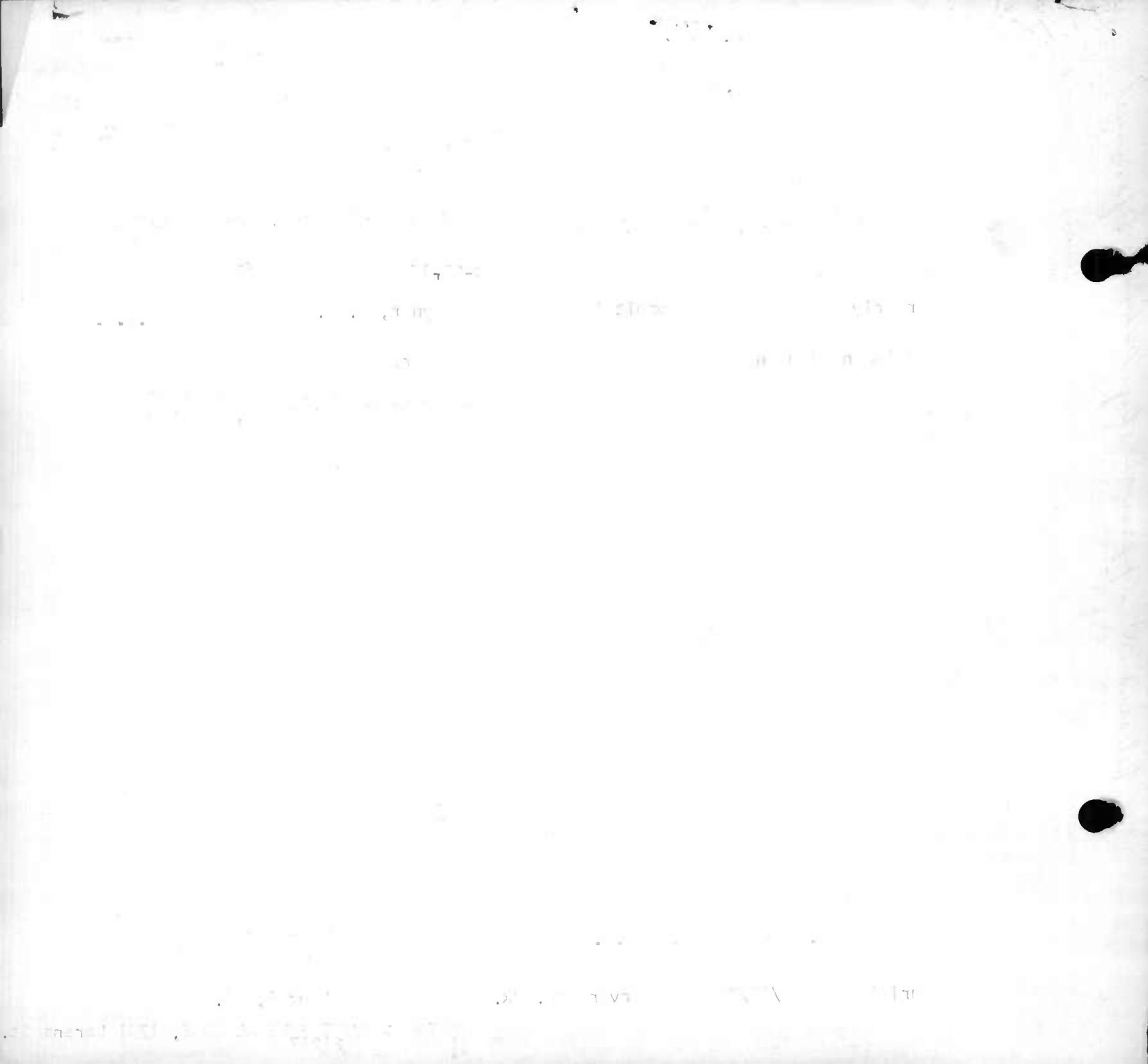
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Robert Milliner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month 9 Day 15 Year 72 Hour 10:15A M.                   |                                                                                               |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>University Hospital 7/10/73                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 15 Year 72 Hour 10:15A M.                                                                                            |                                                                                               |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1402                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             |                                                                                               |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 7. RACE<br>Negro     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN<br>Baltimore                                                                  |
| 9. DATE OF BIRTH<br>7-9-40                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      | 10. AGE (In years lost birthday)<br>32                                                                                                                      | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 11. BIRTHPLACE (State or foreign country)<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                      | E. STREET AND NUMBER<br>646 Mosher Street                                                     |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           | 13. FATHER'S NAME<br>Richard Milliner                                                         |
| 15. MOTHER'S MAIDEN NAME<br>Ada Gordon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                                                                               |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      | 17. SOCIAL SECURITY NO.<br>216342514                                                                                                                        | 18. INFORMANT<br>Ada Milliner                                                                 |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>E9881<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                     |                      | ADDRESS<br>819 Edmondson Ave.                                                                                                                               |                                                                                               |
| 20A. DATE OF OPERATION<br>8-28-72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>draining of hematoma                                                                                    | 21. AUTOPSY? (Yes or No)<br>Yes                                                               |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Unknown                                                         | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>Unknown           |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br>8 27 72 ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                        | 22F. HOW DID INJURY OCCUR?<br>During altercation Unknown                                      |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/><br>ACTUAL SIGNATURE <i>W.P. Mulloy</i> M.D.<br>EXAMINER'S NAME (Type) William P. Mulloy M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 9-16-72 |                      |                                                                                                                                                             |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 24B. DATE<br>9-20-72 | 24C. NAME OF CEMETERY or CREMATORY<br>Mt. Auburn Cem.                                                                                                       | 24D. LOCATION (City, town, or county) (State)<br>Balto., Md.                                  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 25B. NAME OF REGISTRAR<br><i>Andrew H. Hinton</i>                                                                                                           | 25C. FUNERAL DIRECTOR V. ailey<br>Kelson F.H. 1848 Calhoun St.                                |

7/10/73 - Letter from M.E.O., William P. Mulloy, M.D.

APC









FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                    |                        |                                                                                          |                                                                          | REG. NO. <u>72 08934</u>                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------|
| 72 08934<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                    |                        |                                                                                          |                                                                          | STATE OF MARYLAND - DEPT                                             |
| BIRTH NO.                                                                                                                                                                                                                                                                                           |                        | 1. NAME OF DECEASED<br>(Type or Print)                                                   |                                                                          | 2. DATE AND HOUR OF DEATH                                            |
|                                                                                                                                                                                                                                                                                                     |                        | HENRY HAZEL                                                                              |                                                                          | 9-12-72                                                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                              |                        | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)    |                                                                          |                                                                      |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                           |                        | A. STATE B. COUNTY                                                                       |                                                                          |                                                                      |
| 00 519 NORTH SCHROEDER STREET                                                                                                                                                                                                                                                                       |                        | MARYLAND                                                                                 |                                                                          |                                                                      |
|                                                                                                                                                                                                                                                                                                     |                        | C. CITY OR TOWN                                                                          |                                                                          | D. INSIDE CITY LIMITS?                                               |
|                                                                                                                                                                                                                                                                                                     |                        | BALTIMORE                                                                                |                                                                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
|                                                                                                                                                                                                                                                                                                     |                        | E. STREET AND NUMBER                                                                     |                                                                          |                                                                      |
|                                                                                                                                                                                                                                                                                                     |                        | 519 N. SCHROEDER STREET                                                                  |                                                                          |                                                                      |
| 5. SEX                                                                                                                                                                                                                                                                                              | 6. RACE                | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>               | 8. DATE OF BIRTH                                                         | 9. AGE (In years last birthday)                                      |
| M                                                                                                                                                                                                                                                                                                   | B                      | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 3-15-95                                                                  | 77                                                                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                         |                        | 10B. KIND OF BUSINESS OR INDUSTRY                                                        | 11. BIRTHPLACE (State or foreign country)                                | 12. CITIZEN OF WHAT COUNTRY?                                         |
| RETIRED                                                                                                                                                                                                                                                                                             |                        | BALTO. GAS & ELEC.                                                                       | GEORGETOWN, S. C.                                                        | U.S.A.                                                               |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                   |                        | 14. MOTHER'S MAIDEN NAME                                                                 |                                                                          |                                                                      |
| HENRY HAZEL                                                                                                                                                                                                                                                                                         |                        | GRACE WILLIAMS                                                                           |                                                                          |                                                                      |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                            |                        | 16. SOCIAL SECURITY NO.                                                                  | 17. INFORMANT ADDRESS                                                    |                                                                      |
|                                                                                                                                                                                                                                                                                                     |                        | 212-10-3009                                                                              | MRS. EDNA V. HAZEL 519 N. SCHROEDER STREET                               |                                                                      |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                  |                        | CAUSE OF DEATH                                                                           |                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                        |                        | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                                                                          | Sudden                                                               |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                   |                        | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |                                                                          |                                                                      |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                           |                        | Hypertensive Cardiac Vascular Disease                                                    |                                                                          |                                                                      |
| II                                                                                                                                                                                                                                                                                                  |                        | Residual C.V.A.                                                                          |                                                                          | Sept. 1971                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                    |                        | 20A. AUTOPSY? (Yes or No)                                                                |                                                                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                              |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                                                                          | No                                                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                               |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                      |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                       |                        | 21E. INJURY OCCURRED                                                                     | 21F. HOW DID INJURY OCCUR?                                               |                                                                      |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                         |                        | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                                                                          |                                                                      |
| 22. I certify that (I) (this hospital) attended the deceased from 9/3/72 to 8/25/72, that (I) (we) last saw the deceased alive on 8/25/72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |                        |                                                                                          |                                                                          |                                                                      |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                      |                        | 23B. DATE SIGNED                                                                         |                                                                          |                                                                      |
| Joseph S. Blum MD                                                                                                                                                                                                                                                                                   |                        | 9/12/72                                                                                  |                                                                          |                                                                      |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                        |                        | 23D. ADDRESS                                                                             |                                                                          |                                                                      |
| JOSEPH S. BLUM MD                                                                                                                                                                                                                                                                                   |                        | 1115 N. CALVERT ST                                                                       |                                                                          |                                                                      |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                            | 24B. DATE              | 24C. NAME OF CEMETERY OR CREMATORY                                                       | 24D. LOCATION (City, town, or county) (State)                            |                                                                      |
| BURIAL                                                                                                                                                                                                                                                                                              | 9-15-72                | CEDAR HILL CEMETERY                                                                      | BALTIMORE, MARYLAND                                                      |                                                                      |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                     | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS                                                            |                                                                          |                                                                      |
| SEP 18 1972                                                                                                                                                                                                                                                                                         | Sidney [Signature]     | MORTON & DYETT F. H. 1701 LAURENS ST.                                                    |                                                                          |                                                                      |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  | REG. NO. <u>72 18935</u>                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                        |  | 1. NAME OF DECEASED<br>(Type of Print) <u>VIRGIE JOHNSON</u>                                                                       |  | 2. DATE AND HOUR OF DEATH<br><u>9/12/72</u> <u>9:15 P.M.</u>                                                                                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD.</u> B. COUNTY <u>1601</u> |  |                                                                                                                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>38 University of MD. Hospital</u>                                                                                                                                                                                                                                                                                     |  | C. CITY OR TOWN<br><u>BALTIMORE</u>                                                                                                |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                  |  | 6. RACE <u>B</u>                                                                                                                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                  |  | 8. DATE OF BIRTH<br><u>4-14-04</u>                                                                                                                          |
| 13. FATHER'S NAME<br><u>FRANK ROY</u>                                                                                                                                                                                                                                                                                                                            |  | 14. MOTHER'S MAIDEN NAME<br><u>KATE OWENS</u>                                                                                      |  | 9. AGE (In years last birthday)<br><u>68</u>                                                                                                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                         |  | 6. SOCIAL SECURITY NO.                                                                                                             |  | 11. BIRTHPLACE (State or foreign country)<br><u>Va. KESSEY Co</u>                                                                                           |
| 17. INFORMANT<br><u>Dorothy Harris</u>                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br><u>2121 Clifton Ave. 21217</u>                                                                                          |  |                                                                                                                                                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>CIA, hemorrhage</u>                                                                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>approx 6 days</u>                                                               |  |                                                                                                                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Hypertension</u><br><u>Obesity</u>                                                                                                                                                                                          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                                         |  |                                                                                                                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                           |  |                                                                                                                                    |  |                                                                                                                                                             |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                           |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20A. AUTOPSY? (Yes or No)<br><u>yes</u>                                                                                                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                            |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                           |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                 |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                     |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                          |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 6</u> 19 <u>72</u> to <u>Sept. 12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Sept. 12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                                    |  |                                                                                                                                                             |
| 23A. SIGNATURE<br><u>Gemma P. Indol</u> <u>MD</u>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |  | 23B. DATE SIGNED<br><u>8/12/72</u>                                                                                                                          |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                     |  | 23D. ADDRESS                                                                                                                       |  |                                                                                                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                        |  | 24B. DATE<br><u>9-15-72</u>                                                                                                        |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Mt Auburn Ceph</u>                                                                                                 |
| 24D. LOCATION<br><u>Balto Md</u>                                                                                                                                                                                                                                                                                                                                 |  | 24E. LOCATION (City, town, or county) (State)                                                                                      |  |                                                                                                                                                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 18 1972</u>                                                                                                                                                                                                                                                                                                            |  | 25B. NAME OF REGISTRAR<br><u>Ardelya Houston</u>                                                                                   |  | 25C. FUNERAL DIRECTOR<br><u>Robert F. H</u>                                                                                                                 |
| 25D. ADDRESS<br><u>1601-hawkins</u>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  |                                                                                                                                                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                   |  |                                                                                                                                 |  | REG. NO. 98680 24                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH                                                                                                       |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                   |  |
| EDWARD C. YOUNG                                                                                                                                                                                                                                                                                    |  | 3 <sup>40</sup> a.m. 9.12.72 M.                                                                                                 |  | UNION MEMORIAL HOSPITAL                                                                                  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                                                                                                                                              |  | 5. CITY OR TOWN                                                                                                                 |  | 6. INSIDE CITY LIMITS?                                                                                   |  |
| A. STATE B. COUNTY                                                                                                                                                                                                                                                                                 |  | C. CITY OR TOWN                                                                                                                 |  | D. INSIDE CITY LIMITS?                                                                                   |  |
| U.S.A.                                                                                                                                                                                                                                                                                             |  | Baltimore                                                                                                                       |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                      |  |
| 7. STREET AND NUMBER                                                                                                                                                                                                                                                                               |  | 8. DATE OF BIRTH                                                                                                                |  | 9. AGE (In years lost birthday)                                                                          |  |
| 502 Oakland Avenue                                                                                                                                                                                                                                                                                 |  | 9-5-1892                                                                                                                        |  | 80                                                                                                       |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                         |  | 11. BIRTHPLACE (State or foreign country)                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY?                                                                             |  |
| (Textile) KNOWN                                                                                                                                                                                                                                                                                    |  | Essex Co, Virginia                                                                                                              |  | U.S.A.                                                                                                   |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                  |  | 14. MOTHER'S MAIDEN NAME                                                                                                        |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |
| Amos Young                                                                                                                                                                                                                                                                                         |  | Millie Young                                                                                                                    |  | No.                                                                                                      |  |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                            |  | 17. INFORMANT                                                                                                                   |  | ADDRESS                                                                                                  |  |
| 216-09-5744                                                                                                                                                                                                                                                                                        |  | Mr. Charlie Young                                                                                                               |  | Tappahannock, VA.                                                                                        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                 |  | 19. CAUSE OF DEATH                                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                         |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                             |  |                                                                                                          |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                             |  |                                                                                                          |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                          |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                             |  |                                                                                                          |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                |  |                                                                                                                                 |  |                                                                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  | 20A. AUTOPSY? (Yes or No)                                                                                |  |
|                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                          |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                          |  | 21F. HOW DID INJURY OCCUR?                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10/72 to 9/14/72 that (I) (we) last saw the deceased alive on 9/14/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  | 23A. SIGNATURE                                                                                                                  |  | 23B. DATE SIGNED                                                                                         |  |
| Dr. Ruffner                                                                                                                                                                                                                                                                                        |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 9/14/72                                                                                                  |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                       |  | 23D. ADDRESS                                                                                                                    |  |                                                                                                          |  |
| Dr. Ruffner                                                                                                                                                                                                                                                                                        |  | UNION MEMORIAL HOSPITAL                                                                                                         |  |                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                           |  | 24B. DATE                                                                                                                       |  | 24C. NAME OF CEMETERY or CREMATORY                                                                       |  |
| Burial                                                                                                                                                                                                                                                                                             |  | 9/19/72                                                                                                                         |  | St. John Bapt. Ch. Cem.                                                                                  |  |
| 24D. LOCATION (City, town, or county)                                                                                                                                                                                                                                                              |  | 24E. STATE                                                                                                                      |  | 24F. FUNERAL DIRECTOR                                                                                    |  |
| Tappahannock, Virginia                                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  | Gordon D. Dyer F.H.                                                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR                                                                                                          |  | 25C. FUNERAL DIRECTOR ADDRESS                                                                            |  |
| SEP 18 1972                                                                                                                                                                                                                                                                                        |  | D. Dyer                                                                                                                         |  | 1701 Laurens St.                                                                                         |  |

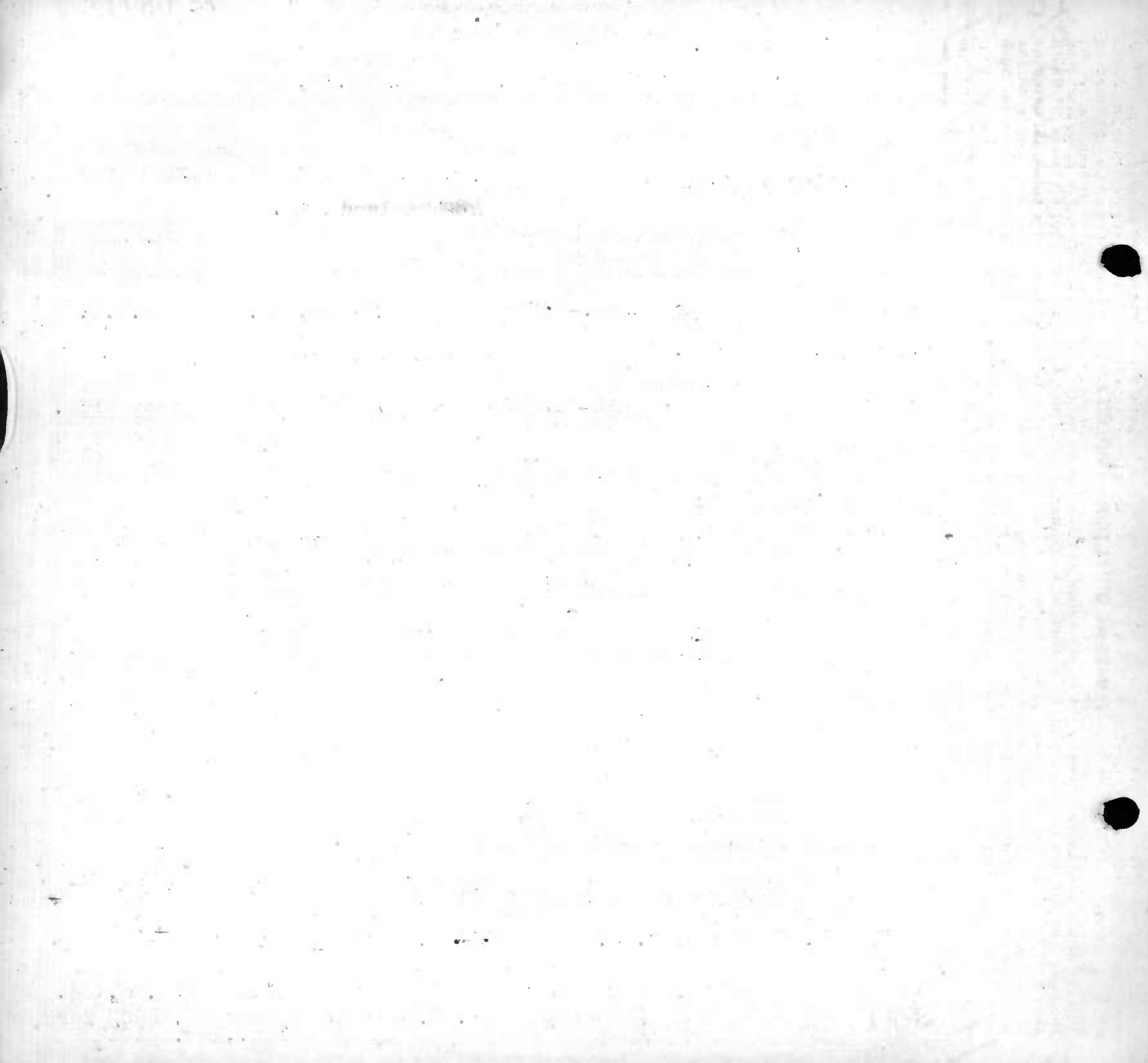
22



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                   | 72 08937                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                   | REG. NO. 72 08937                                                                                                                    |
| BIRTH NO. <span style="font-size: 2em;">S-500</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                          | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.5em;">Jessie Leitch Snow</span>                                                                                                                                                                                                                                                                                                                                                           |                                                                   | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.5em;">Sept. 15, 1972</span> <span style="float: right;">7:30 P.M.</span>      |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><span style="font-size: 2em;">90</span> <span style="font-size: 1.5em;">Anderson Nursing Home</span>                                                                                                                                                                                                                                                                                                                             |                                                          | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.5em;">Maryland</span><br>B. COUNTY <span style="font-size: 2em;">2714</span><br>C. CITY OR TOWN <span style="font-size: 1.5em;">Baltimore</span><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <span style="font-size: 1.5em;">4824 Roland Ave.</span> |                                                                   |                                                                                                                                      |
| 5. SEX <span style="font-size: 1.5em;">F</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE <span style="font-size: 1.5em;">W</span>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                | 8. DATE OF BIRTH <span style="font-size: 1.5em;">4/13/1887</span> | 9. AGE (In years last birthday) <span style="font-size: 1.5em;">85</span>                                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Manager</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                          | 10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.5em;">Snow Bldg.-Office</span>                                                                                                                                                                                                                                                                                                                                                                 |                                                                   | 11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Baltimore, Md.</span>                                      |
| 13. FATHER'S NAME <span style="font-size: 1.5em;">Henry Snow</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                          | 14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Johanna Williams</span>                                                                                                                                                                                                                                                                                                                                                                           |                                                                   |                                                                                                                                      |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.5em;">No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                          | 16. SOCIAL SECURITY NO. <span style="font-size: 1.5em;">214-34-2866</span>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   | 17. INFORMANT <span style="font-size: 1.5em;">George V. Parkhurst</span> ADDRESS <span style="font-size: 1.5em;">Munsey Bldg.</span> |
| 18. <span style="font-size: 2em;">412.31</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                           |                                                          | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Coronary Sclerotic Heart Disease - 5 yrs.</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Cerebral Vascular Accident 6 months</span><br>(C) <span style="font-size: 1.5em;">Generalized Arterio Sclerosis</span>                                                                                                       |                                                                   |                                                                                                                                      |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><span style="font-size: 2em;">II</span> <span style="font-size: 1.5em;">Chronic Brain Syndrome</span>                                                                                                                                                                                                                                                                                                                                                                       |                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">—</span>                                                                                                                                                                                                                                                                                                                                                                      |                                                                   |                                                                                                                                      |
| 19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                   | 20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">No</span>                                                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                          | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                   |                                                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                          | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                  |                                                                   | 21F. HOW DID INJURY OCCUR?                                                                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">March 20</span> 19 <span style="font-size: 1.5em;">71</span> to <span style="font-size: 1.5em;">Sept. 15</span> 19 <span style="font-size: 1.5em;">72</span> , that (I) <del>(we)</del> last saw the deceased alive on <span style="font-size: 1.5em;">Sept. 15</span> 19 <span style="font-size: 1.5em;">72</span> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death. |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                   |                                                                                                                                      |
| 23A. SIGNATURE <span style="font-size: 1.5em;">Earl L. Chambers M.D.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                          | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                            |                                                                   | 23B. DATE SIGNED <span style="font-size: 1.5em;">9/16/72</span>                                                                      |
| 23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Earl L. Chambers, M. D.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                          | 23D. ADDRESS <span style="font-size: 1.5em;">100 W. Cold Spring Lane (T-5)</span>                                                                                                                                                                                                                                                                                                                                                                          |                                                                   |                                                                                                                                      |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 24B. DATE <span style="font-size: 1.5em;">9/18/72</span> | 24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.5em;">Druid Ridge</span>                                                                                                                                                                                                                                                                                                                                                                      |                                                                   | 24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Pikesville, Balto. Col. Md.</span>                     |
| 25A. DATE RECEIVED BY HEALTH DEPT. <span style="font-size: 1.5em;">SEP 18 1972</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                          | 25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">H. W. Jenkins</span>                                                                                                                                                                                                                                                                                                                                                                                |                                                                   | 25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.5em;">H. W. Jenkins &amp; Sons Co. 4905 York Rd Balto., Md. 21212</span>     |

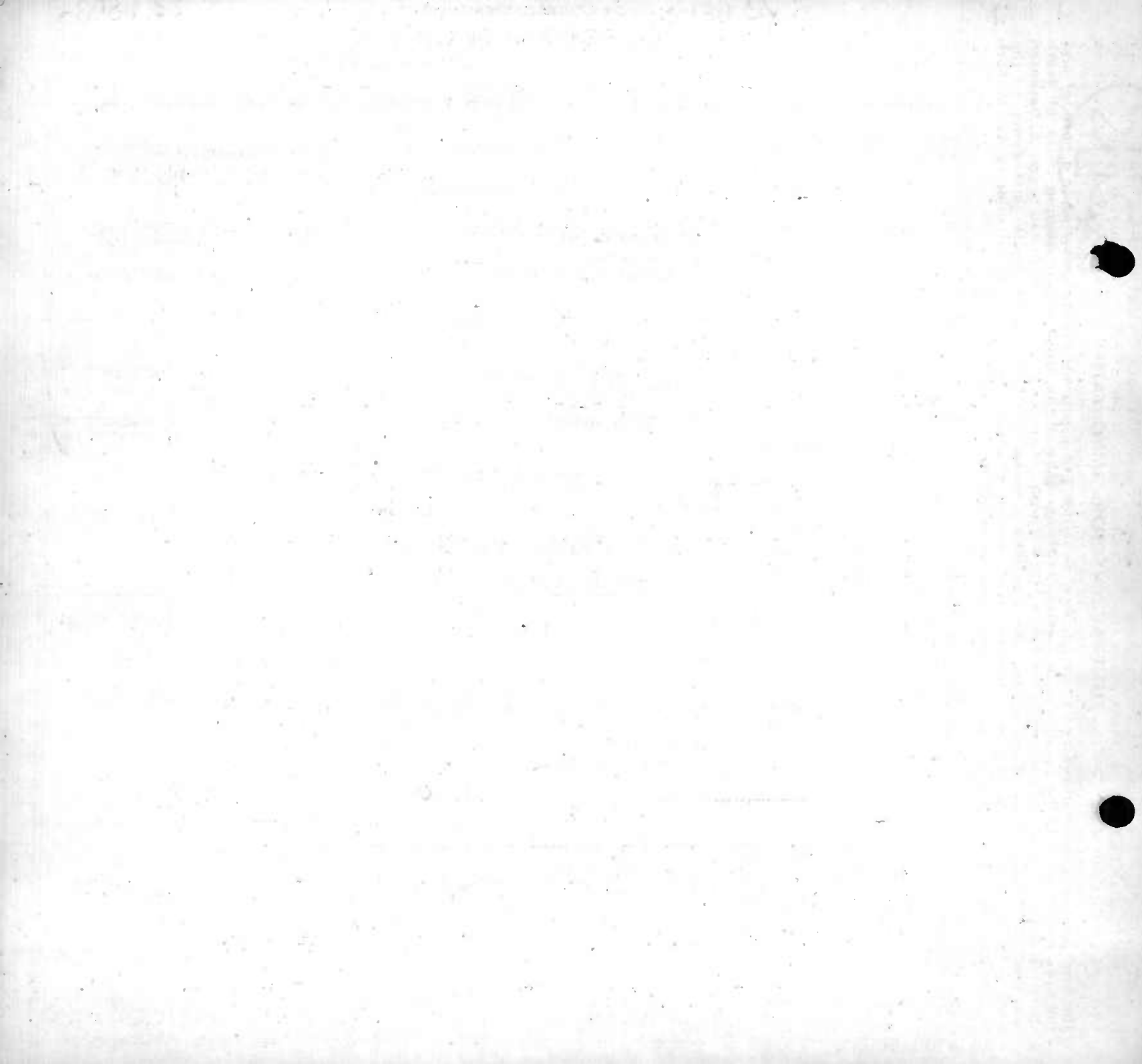




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

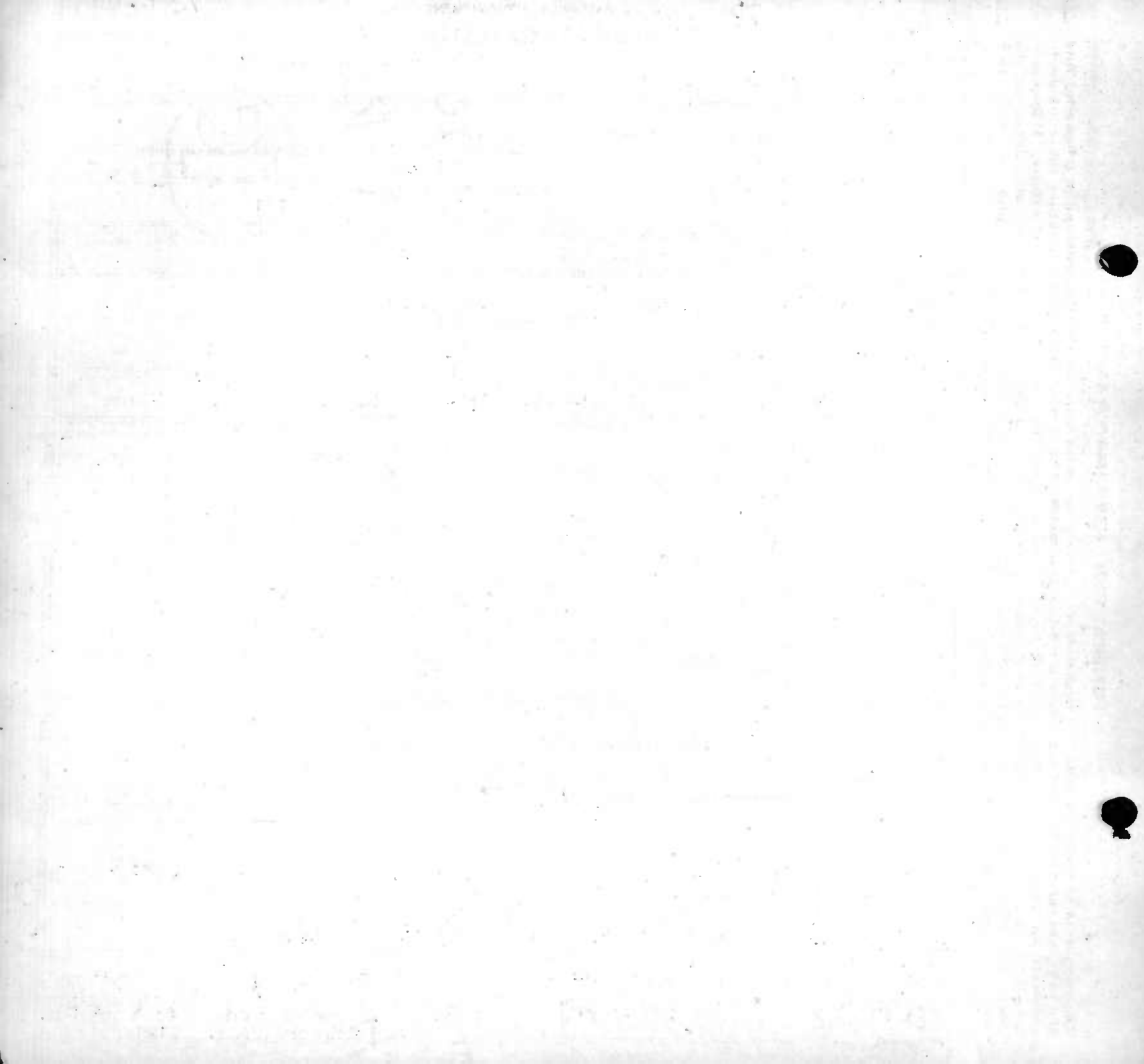
|                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                             |                            |                                                                                               |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                    |              | 72 08938                                                                                                                                                    |                            | 72 08938                                                                                      |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                           |              | M-620                                                                                                                                                       |                            | 1                                                                                             |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                              |              | Christian Emmerich Mears                                                                                                                                    |                            | 2. DATE AND HOUR OF DEATH<br>9-17-72 2:30 a.m.                                                |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                              |              | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE Md.<br>B. COUNTY                                          |                            | 2712                                                                                          |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>00 217 Paddington Rd.                                                                                                                                                                                                                                                                                                       |              | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                            | C. CITY OR TOWN<br>Baltimore                                                                  |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                             |                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                             |                            | E. STREET AND NUMBER<br>217 Paddington Rd.                                                    |                                                           |
| 5. SEX<br>M                                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br>W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>4-5-94 | 9. AGE (In years last birthday)<br>78                                                         | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Executive                                                                                                                                                                                                                                                            |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Flour Grain                                                                                                            |                            | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                              |                                                           |
| 13. FATHER'S NAME<br>Adelbert W. Mears                                                                                                                                                                                                                                                                                                                              |              | 14. MOTHER'S MAIDEN NAME<br>Ellen Emmerich                                                                                                                  |                            | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                           |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes WW I                                                                                                                                                                                                                                                |              | 16. SOCIAL SECURITY NO.<br>219-14-2084                                                                                                                      |                            | 17. INFORMANT<br>Cecile H. Mears                                                              |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                     |              |                                                                                                                                                             |                            | ADDRESS<br>Same                                                                               |                                                           |
| 18. <del>188X</del> I                                                                                                                                                                                                                                                                                                                                               |              | CAUSE OF DEATH                                                                                                                                              |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                                           |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                      |              | (A) IMMEDIATE CAUSE<br>Ca bladder with wide-spread metastases                                                                                               |                            | 30 years                                                                                      |                                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                      |              | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                            |                                                                                               |                                                           |
|                                                                                                                                                                                                                                                                                                                                                                     |              | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                            |                                                                                               |                                                           |
| II                                                                                                                                                                                                                                                                                                                                                                  |              | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Old cerebral thrombosis |                            |                                                                                               |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                            | 20A. AUTOPSY? (Yes or No)<br>no                                                               |                                                           |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                             |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                            | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |                                                           |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                        |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                            | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 8/3/70 to 9/17/72, that (I) ( <del>we</del> ) last saw the deceased alive on 9/17/72 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death. |              |                                                                                                                                                             |                            |                                                                                               |                                                           |
| 23A. SIGNATURE<br>John R. Davis M.D.                                                                                                                                                                                                                                                                                                                                |              |                                                                                                                                                             |                            | 23B. DATE SIGNED<br>9/18/72                                                                   |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br>John R. Davis M.D.                                                                                                                                                                                                                                                                                                                  |              |                                                                                                                                                             |                            | 23D. ADDRESS<br>Medical Arts Bldg.                                                            |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                  |              | 24B. DATE<br>9-20-72                                                                                                                                        |                            | 24C. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery                                       |                                                           |
| 24D. LOCATION<br>Baltimore, Co.                                                                                                                                                                                                                                                                                                                                     |              | 24E. LOCATION<br>Md.                                                                                                                                        |                            | 24F. LOCATION<br>Md.                                                                          |                                                           |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br>SEP 18 1972                                                                                                                                                                                                                                                                                                                   |              | 25B. NAME OF REGISTRAR<br>Henry W. Jenkins Sons                                                                                                             |                            | 25C. FUNERAL DIRECTOR<br>4905 York Rd. Baltimore, Md. 21212                                   |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

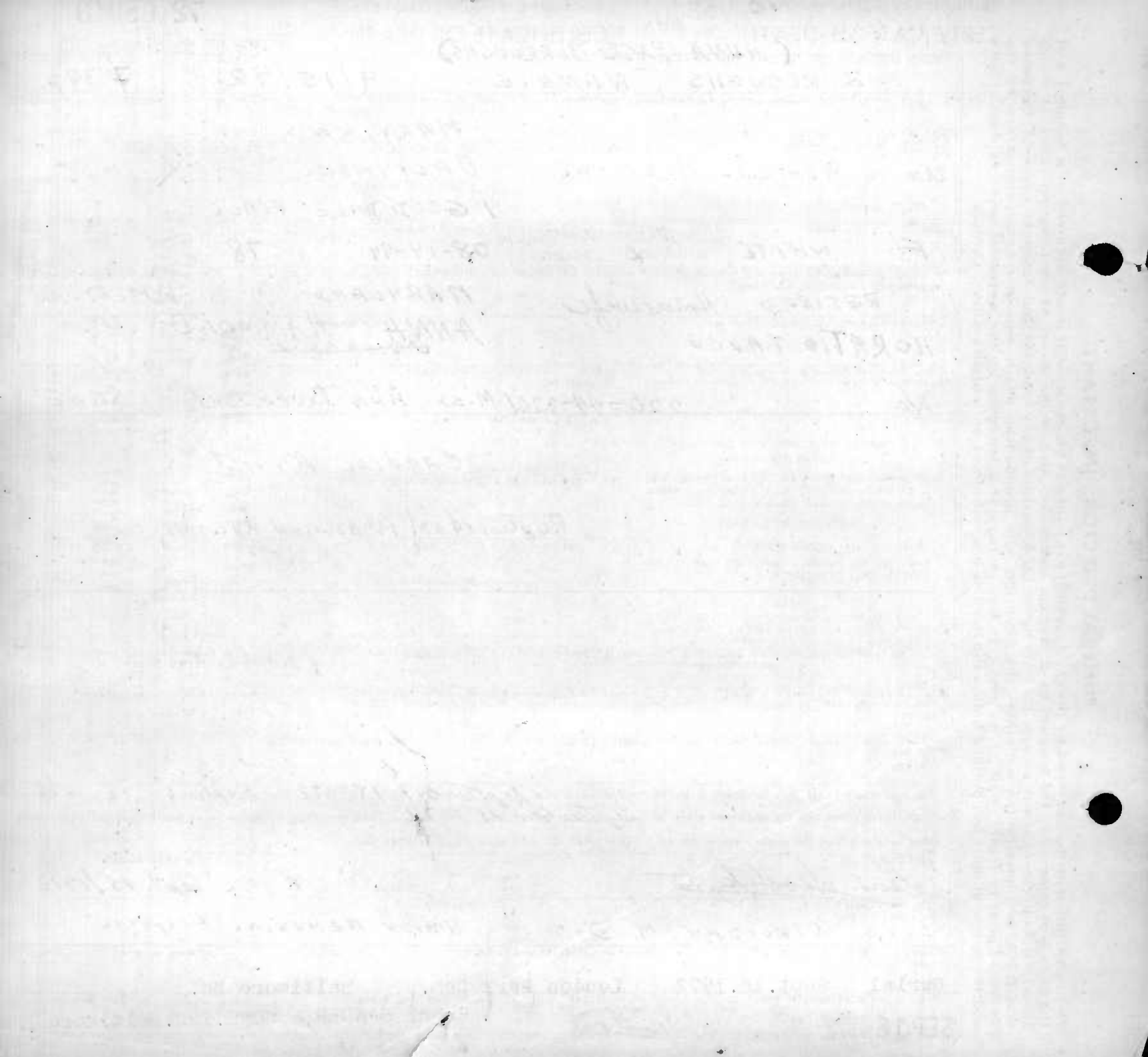
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                             |                             |                                                                                               |                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| L-220<br>72 08939                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                             |                             | REG. NO. 72 08939<br>STATE OF MARYLAND - DEATH                                                |                                                                   |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |              | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                             | 2. DATE AND HOUR OF DEATH                                                                     |                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              | William S. Lucas, Sr.                                                                                                                                       |                             | 9-18-72 2:45 A.M.                                                                             |                                                                   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY                                                 |                             |                                                                                               |                                                                   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>00 5714 Leithwalk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                             | Md. 2748                                                                                      |                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              | C. CITY OR TOWN<br>Baltimore                                                                                                                                |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              | E. STREET AND NUMBER<br>5714 Leithwalk 21212                                                                                                                |                             |                                                                                               |                                                                   |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. RACE<br>W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>5-22-95 | 9. AGE (In years last birthday)<br>77                                                         | 10. If Under 1 Yr. Months Days<br>11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Ret. Court Clerk                                                                                                                                                                                                                                                                                                                                                                                                                                       |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>State                                                                                                                  |                             | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                         |                                                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |              | 13. FATHER'S NAME<br>Samuel M. Lucas                                                                                                                        |                             | 14. MOTHER'S MAIDEN NAME<br>Mary R. Bowers                                                    |                                                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>yes WW I Army                                                                                                                                                                                                                                                                                                                                                                                                                             |              | 16. SOCIAL SECURITY NO.<br>220-36-6690                                                                                                                      |                             | 17. INFORMANT<br>Agnes Elaine Lucas                                                           |                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |              |                                                                                                                                                             |                             | ADDRESS<br>Same                                                                               |                                                                   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>162.1 I<br>CAUSE OF DEATH<br>A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>Pneumonia<br><br>B. DUE TO, OR AS A CONSEQUENCE OF:<br><br>C. DUE TO, OR AS A CONSEQUENCE OF:<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>Emphysema |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>7 min.                                                                                                      |                             |                                                                                               |                                                                   |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                             | 20A. AUTOPSY? (Yes or No)<br>no                                                               |                                                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                     |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                                   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                             | 21F. HOW DID INJURY OCCUR?                                                                    |                                                                   |
| 22. I certify that (I) (this hospital) attended the deceased from 9/17/72 19 to 9/18/72 19 that (I) (we) last saw the deceased alive on 9/17/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                           |              |                                                                                                                                                             |                             |                                                                                               |                                                                   |
| 23A. SIGNATURE<br>Walter Karfgin M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |              | 23B. DATE SIGNED<br>9/18/72                                                                                                                                 |                             | 23C. PHYSICIAN'S NAME (Type)<br>Walter Karfgin M.D.                                           |                                                                   |
| 23D. ADDRESS<br>4331 Harford Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              | 23E. ATTENDING PHYSICIAN<br>Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>           |                             |                                                                                               |                                                                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |              | 24B. DATE<br>9-20-72                                                                                                                                        |                             | 24C. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery                                    |                                                                   |
| 24D. LOCATION (City, town, or county) (State)<br>Pikesville Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 18 1972                                                                                                              |                             | 25B. NAME OF REGISTRAR<br>Henry W. Jenkins Sons                                               |                                                                   |
| 25C. FUNERAL DIRECTOR<br>Henry W. Jenkins Sons                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              | 25D. ADDRESS<br>4905 York Rd. Baltimore, Md. 21212                                                                                                          |                             |                                                                                               |                                                                   |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                     | REG. NO. 72 08940                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------|
| B-622 12 08940<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                     | STATE OF MARYLAND-DEMH                                                                        |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BURROUGHS, NANNIE</b>                                                                                                                                                                                                                                                                                            |                         | 2. DATE AND HOUR OF DEATH<br><b>9/15/72 7.30 P. M.</b>                                                                                                      |                                     |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                     |                         | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)                                                                       |                                     |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Memorial Hospital</b>                                                                                                                                                                                                                                                                                     |                         | A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2712</b>                                                                                                           |                                     |                                                                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                       |                         | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                         |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| <b>44</b>                                                                                                                                                                                                                                                                                                                                                  |                         | E. STREET AND NUMBER<br><b>1 GOODALE PLACE</b>                                                                                                              |                                     |                                                                                               |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>08-14-94</b> | 9. AGE (In years lost birthday) <b>78</b>                                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>                                                                                                                                                                                                                                              |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>                                                                                                       |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>AMERICAN</b>                                               |
| 13. FATHER'S NAME<br><b>HORATIO TAVAU</b>                                                                                                                                                                                                                                                                                                                  |                         | 14. MOTHER'S M maiden name<br><b>ANNA HAMMOND</b>                                                                                                           |                                     |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                      |                         | 16. SOCIAL SECURITY NO.<br><b>220-44-3261</b>                                                                                                               |                                     | 17. INFORMANT<br><b>Miss Ann Burroughs</b>                                                    |
| 18. <b>44121</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIAC ARREST</b>                                                                                                                |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |                                     |                                                                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>Ruptured of Abdominal Aneurism</b>                                                                                                                                                                                    |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                     |                                     |                                                                                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                     |                                                                                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                     | 20A. AUTOPSY? (Yes or No)                                                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                      |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                     | 21F. HOW DID INJURY OCCUR?                                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from <b>September 15, 1972</b> to <b>September 15, 1972</b> , that (I) (we) last saw the deceased alive on <b>September 15, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                     |                                                                                               |
| 23A. SIGNATURE<br><b>Luis Sirotzky, M.D.</b>                                                                                                                                                                                                                                                                                                               |                         | 23B. DATE SIGNED<br><b>Sept. 15/1972</b>                                                                                                                    |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>LUIS SIROTZKY, M.D.</b>                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><b>Sept. 18, 1972</b>                                                                                                                          |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cem.</b>                                 |
| 24D. LOCATION (City, town, or county)<br><b>Baltimore Md.</b>                                                                                                                                                                                                                                                                                              |                         | 24E. FUNERAL DIRECTOR<br><b>HENRY SANDER &amp; SONS, INC. Baltimore Md</b>                                                                                  |                                     |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 18 1972</b>                                                                                                                                                                                                                                                                                                      |                         | 25B. NAME OF REGISTRAR<br><b>Henry Sander</b>                                                                                                               |                                     | 25C. ADDRESS<br><b>Baltimore Md</b>                                                           |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) (Boulware)<br>Robert Boller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 9 14 72 11:47A.M.                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1851 Kavanaugh Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 14 72 11:47A.M.                                                                                                                   |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1502                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. SEX Male 7. RACE Negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>July 8, 1897 10. AGE (In years lost birthday) 75                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | E. STREET AND NUMBER<br>1851 Kavanaugh Street                                                                                                                                         |  |
| 11. BIRTHPLACE (State or foreign country)<br>South Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                   |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13. FATHER'S NAME<br>Robert Boller                                                                                                                                                    |  |
| 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>Sukie Jones                                                                                                                                               |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 17. SOCIAL SECURITY NO.<br>220-09-2842                                                                                                                                                |  |
| 18. INFORMANT<br>Miss Thomasina Boller                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS<br>1851 Kavanaugh Street                                                                                                                                                      |  |
| 19. CAUSE OF DEATH<br>412.21<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>(A) IMMEDIATE CAUSE Hypertensive cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                          |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                      |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                              |  |
| 22D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                              |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) DATE SIGNED 9-14-72<br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |                                                                                                                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br>9-18-72                                                                                                                                                                  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Baltimore National                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                                                                                                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 19 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 25B. NAME OF REGISTRAR<br>Arlington S. Phillips                                                                                                                                       |  |
| 25C. FUNERAL DIRECTOR<br>Arlington S. Phillips                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS<br>1727 N. Monroe Street                                                                                                                                                      |  |



1000 57

U.S. DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 1, 1900

My dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,

Wm. H. Wood

Secretary

U.S. DEPARTMENT OF COMMERCE

WASHINGTON, D. C.

January 1, 1900

My dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

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Your obedient servant,

Wm. H. Wood



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                    |                                                                          |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------|
| C-455<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                    |                         | 72 08942<br>BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                |                                                                                                                                                                                                                                                                                                                                    | REG. NO. 72 08942<br>STATE OF MARYLAND-DEATH                             |                                                                |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Alvester Coleman</b>                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>12:20am Date 9/17/72                                                                                                                                                                                                                                                                                  |                                                                          |                                                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>39 Provident Hospital</b>                                                                                                                                               |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Baltimore County</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>110 Wesley Avenue</b> |                                                                          |                                                                |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><b>Black</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>03/06/06</b>                                                                                                                                                                                                                                                                                                | 9. AGE (In years last birthday)<br><b>66</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                         |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                                                                                                                                                                                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |                                                                |
| 13. FATHER'S NAME<br><b>Lee Coleman</b>                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Rosa Wright</b>                                                                                                                                                                                                                                                                                     |                                                                          |                                                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                              |                         | 16. SOCIAL SECURITY NO.<br><b>217-01-4446</b>                                                                                                               | 17. INFORMANT<br><b>Lee Garnett Coleman, Sr.</b> ADDRESS<br><b>Baltimore, County</b><br><b>15807 Leewood Ave</b>                                                                                                                                                                                                                   |                                                                          |                                                                |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Gram Negative sepsis</b>                                                                                                                     |                         |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Gram Negative sepsis</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                 |                                                                          |                                                                |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>pneumonia; Diabetes Mellitus; Abscess of Gangrene Rt Foot (Amputated 9/18/72)</b>                                                                                                                          |                         |                                                                                                                                                             | ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                     |                                                                          |                                                                |
| 19A. DATE OF OPERATION<br><b>9/18/72</b>                                                                                                                                                                                                                                                                                                              |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Gangrene, Rt Foot</b>                                                                                |                                                                                                                                                                                                                                                                                                                                    | 20A. AUTOPSY? (Yes or No)                                                |                                                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                 |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                         |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                    | 21F. HOW DID INJURY OCCUR?                                               |                                                                |
| 22. I certify that (I) (this hospital) attended the deceased from <b>August 13, 1972</b> to <b>September 17, 1972</b> that (I) (we) last saw the deceased alive on <b>September 17, 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                    |                                                                          |                                                                |
| 23A. SIGNATURE<br><b>Marcos B. Galicia Jr. MD</b>                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><b>9/17/72</b>                                                                                                                                                                                                                                                                                                 |                                                                          | 23C. PHYSICIAN'S NAME (Type)<br><b>MARCO B. GALICIA JR. MD</b> |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                              |                         | 24B. DATE<br><b>9-20-72</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Cedar Hill</b>                  |                                                                |
| 24D. LOCATION (City, town, or county)                                                                                                                                                                                                                                                                                                                 |                         | 24E. FUNERAL DIRECTOR<br><b>W. J. Phillips</b>                                                                                                              |                                                                                                                                                                                                                                                                                                                                    | 24F. ADDRESS<br><b>1727 N. Mount St.</b>                                 |                                                                |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                       |                         | 25B. NAME OF REGISTRAR<br><b>W. J. Phillips</b>                                                                                                             |                                                                                                                                                                                                                                                                                                                                    | 25C. FUNERAL DIRECTOR<br><b>W. J. Phillips</b>                           |                                                                |

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

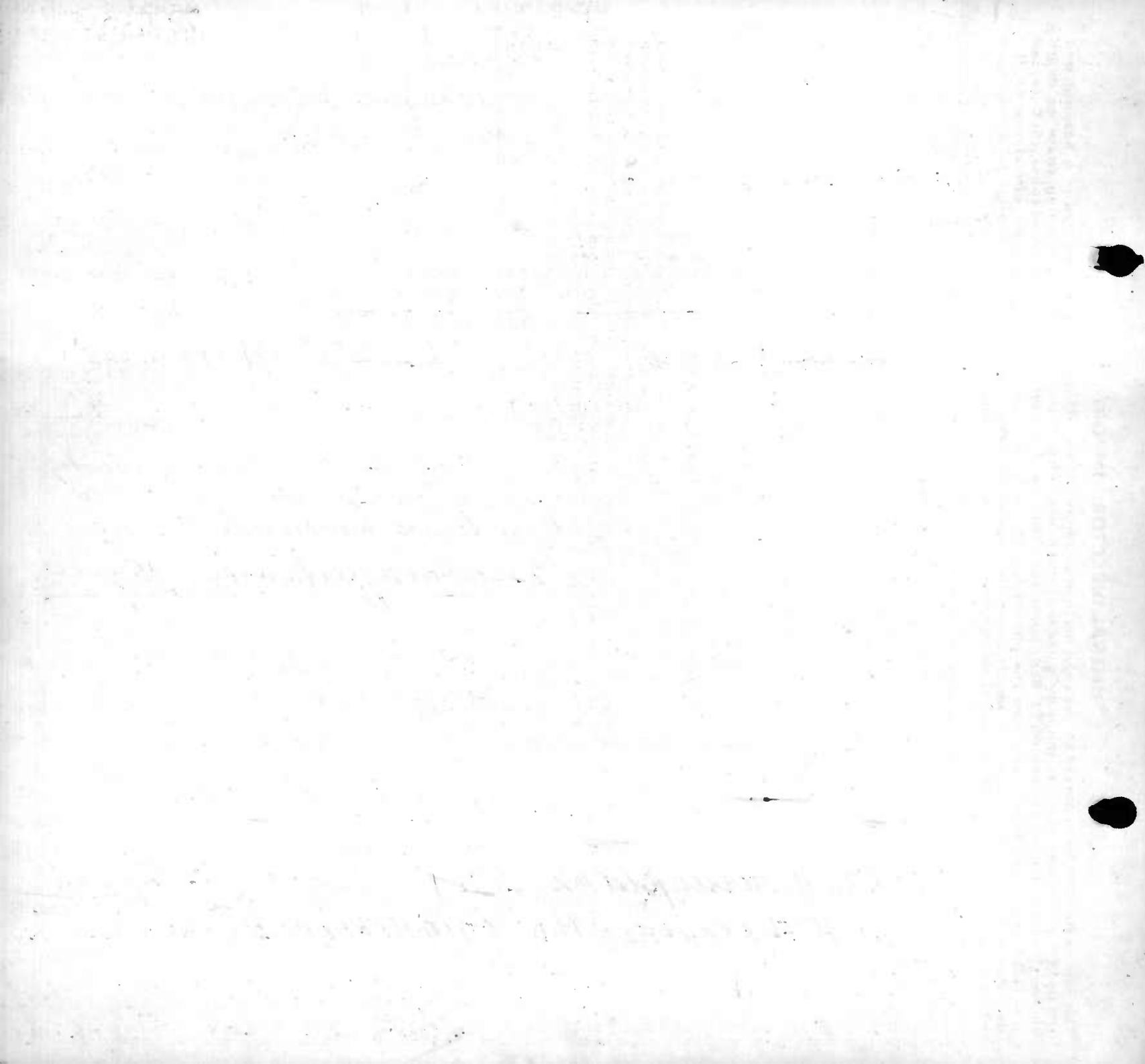
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                                                                                                | REG. NO. <u>72 08943</u><br><u>STATE OF MARYLAND-DEATH</u>                          |                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| BIRTH NO. <u>R-263</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 72 08943                                                                                                                                                    |                                                                                                                                                                                                                |                                                                                     |                                                                                                    |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Ralph W. Rushworth</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><u>Sept. 14, 1972</u> <u>6:05 P</u> M.                                                                                                                                            |                                                                                     |                                                                                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>90 Hood Nursing Home</u>                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2006</u>                                                                     |                                                                                     |                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                                                            |                                                                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | E. STREET AND NUMBER<br><u>533 S. Longwood Street</u>                                                                                                                                                          |                                                                                     |                                                                                                    |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8/9/1896</u>                                                                                                                                                                            | 9. AGE (In years last birthday)<br><u>76</u>                                        | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Sound Engineer</u>                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>R.C.A.</u>                                                                                                          |                                                                                                                                                                                                                | 11. BIRTHPLACE (State or foreign country)<br><u>England</u>                         |                                                                                                    |
| 13. FATHER'S NAME<br><u>Joseph P. Rushworth</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Mary Walker</u>                                                                                                                                                                 |                                                                                     |                                                                                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 16. SOCIAL SECURITY NO.<br><u>216-09-4232</u>                                                                                                               |                                                                                                                                                                                                                | 17. INFORMANT<br><u>Mrs Frances Amorose Nottingham Way</u> ADDRESS <u>7909</u>      |                                                                                                    |
| 18. <u>519.3 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Encephalopathy after surgery</u> |                         |                                                                                                                                                             | CAUSE OF DEATH<br><u>Hypertensive Pulmonary Terminal</u><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Chronic obstructive lung disease</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>3 years</u><br><u>6 months</u> |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                | 20A. AUTOPSY? (Yes or No)                                                           |                                                                                                    |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |                                                                                                    |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                           |                                                                                                                                                                                                                | 21F. HOW DID INJURY OCCUR?                                                          |                                                                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from <u>5/14</u> 19 <u>65</u> to <u>9/14</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>9/14/64</u> 19 <u>64</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                                                                                                                                                                                |                                                                                     |                                                                                                    |
| 23A. SIGNATURE<br><u>Edwin W. Johnson M.D.</u> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                                                                                | 23B. DATE SIGNED                                                                    |                                                                                                    |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 23D. ADDRESS                                                                                                                                                |                                                                                                                                                                                                                |                                                                                     |                                                                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 24B. DATE<br><u>9/18/1972</u>                                                                                                                               |                                                                                                                                                                                                                | 24C. NAME of CEMETERY or CREMATORY<br><u>Mt. Olivet</u>                             |                                                                                                    |
| 24D. LOCATION (City, town, or county)<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 24E. (State)                                                                                                                                                |                                                                                                                                                                                                                |                                                                                     |                                                                                                    |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 19 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 25B. NAME OF REGISTRAR<br><u>Sidney Johnson</u>                                                                                                             |                                                                                                                                                                                                                | 25C. FUNERAL DIRECTOR<br><u>G. Truman Schwab</u> ADDRESS <u>3512 Frederick Ave.</u> |                                                                                                    |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE<br>BUREAU OF VITAL STATISTICS                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                                                                                                                                                                                              |                                                                 | STATE OF MARYLAND - BALTIMORE                                                                                           |                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 72 08944                                                                                                                                                                                                                                                                                                                                                                                     |                      | 72 08944                                                                                                                                                                                                                                                                                                                     |                                                                 | REG. NO. 72 08944                                                                                                       |                                                           |
| BIRTH NO. <u>S-122</u>                                                                                                                                                                                                                                                                                                                                                                       |                      | 1. NAME OF DECEASED<br>(Type or Print) <u>SFEKAS, STELLA</u>                                                                                                                                                                                                                                                                 |                                                                 | 2. DATE AND HOUR OF DEATH<br><u>9-12-72</u> <u>10 15</u> A.M.                                                           |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><u>HAMILTON NURSING CENTER</u><br><u>90</u>                                                                                                                                                                                                                                            |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u><br>C. CITY OR TOWN <u>TIMONIUM</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <u>207 FELTON RD.</u> <u>21093</u> |                                                                 |                                                                                                                         |                                                           |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                  | 8. DATE OF BIRTH <u>3-17-1892</u>                               | 9. AGE (In years lost birthday) <u>80</u>                                                                               | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED.</u>                                                                                                                                                                                                                                                                                  |                      | 10B. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>                                                                                                                                                                                                                                                                           | 11. BIRTHPLACE (State or foreign country) <u>CHIOS, GREECE</u>  |                                                                                                                         | 12. CITIZEN OF WHAT COUNTRY? <u>GREECE</u>                |
| 13. FATHER'S NAME <u>NICKOLAS POULOS</u>                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME <u>KRISTATSON LAS</u>                  |                                                                                                                         |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>                                                                                                                                                                                                                                                                           |                      | 16. SOCIAL SECURITY NO. <u>215-56-1499-T</u>                                                                                                                                                                                                                                                                                 | 17. INFORMANT ADDRESS <u>CECELIA SANDKUHNER 4405 BERGER AVE</u> |                                                                                                                         |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>410.01</u>                                                                                                                                                                          |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Myocardial Infarction</u><br><u>Severe Myocardial Ischemia</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Hypertensive Cardiovascularis</u><br>(C) <u>Essential Hypertension</u>                                                               |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>instantly</u><br><u>8 weeks</u><br><u>5 years</u><br><u>15 years</u> |                                                           |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                           |                      |                                                                                                                                                                                                                                                                                                                              |                                                                 |                                                                                                                         |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                       |                      |                                                                                                                                                                                                                                                                                                                              |                                                                 |                                                                                                                         |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                             |                                                                 | 20A. AUTOPSY? (Yes or No)                                                                                               |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                        |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                     |                                                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                    |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                       |                                                                 | 21F. HOW DID INJURY OCCUR?                                                                                              |                                                           |
| 22. I certify that (I) <del>(did not)</del> attended the deceased from <u>8/28</u> 19 <u>72</u> to <u>9/12</u> 19 <u>72</u> , that (I) <del>(was)</del> last saw the deceased alive on <u>9/11</u> 19 <u>72</u> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did not)</del> (did not) view the body after death. |                      |                                                                                                                                                                                                                                                                                                                              |                                                                 |                                                                                                                         |                                                           |
| 23A. SIGNATURE <u>John H. Hirschfeld M.D.</u>                                                                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                                                                                                                                                                                              |                                                                 | 23B. DATE SIGNED <u>9/12/72</u>                                                                                         |                                                           |
| 23C. PHYSICIAN'S NAME (Type) <u>JOHN H. HIRSCHFELD M.D.</u>                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                                                                                                                                                                                              |                                                                 | 23D. ADDRESS <u>6919 HARFORD ROAD Baltimore Md 21234</u>                                                                |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                       |                      | 24B. DATE <u>9-15-72</u>                                                                                                                                                                                                                                                                                                     |                                                                 | 24C. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>                                                             |                                                           |
| 24D. LOCATION (City, town, or county) <u>WOODLAWN, MD</u>                                                                                                                                                                                                                                                                                                                                    |                      | 24E. LOCATION (State) <u>21207</u>                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                         |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1972</u>                                                                                                                                                                                                                                                                                                                                           |                      | 25B. NAME OF REGISTRAR <u>Andrew J. Johnson</u>                                                                                                                                                                                                                                                                              |                                                                 | 25C. FUNERAL DIRECTOR ADDRESS <u>WM COOK &amp; BROS TOWSON TOWSON, MD 21204</u>                                         |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                  | 72 08945                                                                                                                                                                                                                                                                                                                   |                                                              | 72 08945                                                                    |                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------|
| BIRTH NO. <u>K-620</u>                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                                                  | REG. NO. <u>STATE OF MARYLAND-DEM</u>                                                                                                                                                                                                                                                                                      |                                                              | 72 08945                                                                    |                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Michael Kurowski</u>                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                  | 2. DATE AND HOUR OF DEATH<br><u>9/13/72</u> <u>11:55</u> A.M.                                                                                                                                                                                                                                                              |                                                              |                                                                             |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Mercy Hospital</u>                                                                                                                                                          |                         |                                                                                                                                                             |                                                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u><br>C. CITY OR TOWN <u>Towson</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <u>601 Horncrest Road</u> |                                                              |                                                                             |                                               |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/20/89</u>                               | 9. AGE (In years last birthday)<br><u>82</u>                                                                                                                                                                                                                                                                               | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.    |                                                                             |                                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Barber</u>                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                |                                                                                                                                                                                                                                                                                                                            | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u> |                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
| 13. FATHER'S NAME<br><u>Michael Kurowski</u>                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Anna Andrysiak</u>                                                                                                                                                                                                                                                                     |                                                              |                                                                             |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                     |                         | 16. SOCIAL SECURITY NO.<br><u>213-10-2423 A</u>                                                                                                             | 17. INFORMANT ADDRESS<br><u>Edward A. Kowalewski Same as # 4</u> |                                                                                                                                                                                                                                                                                                                            |                                                              |                                                                             |                                               |
| 18. <u>443.91</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |                         |                                                                                                                                                             |                                                                  | (A) IMMEDIATE CAUSE <u>Myocardial Infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____                                                                                                                                                                      |                                                              |                                                                             |                                               |
| <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                  |                                                                                                                                                                                                                                                                                                                            |                                                              |                                                                             |                                               |
| 19A. DATE OF OPERATION<br><u>19-7-72</u>                                                                                                                                                                                                                                                                                                                  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>peripheral vasc. disease</u>                                                                         |                                                                  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                                                                                                                                                                                                                                                     |                                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                            |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                   |                                                              |                                                                             |                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                 |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                 |                                                              |                                                                             |                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                |                         |                                                                                                                                                             |                                                                  |                                                                                                                                                                                                                                                                                                                            |                                                              |                                                                             |                                               |
| 23A. SIGNATURE<br><u>Eugene J. Strasser M.D.</u><br>OEGREE                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                  | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                           |                                                              | 23C. PHYSICIAN'S NAME (Type)<br><u>Eugene J. STRASSER M.D.</u><br>OEGREE    |                                               |
| 24A. BURIAL CEMETERY, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                  |                         | 24B. DATE<br><u>9-16-72</u>                                                                                                                                 |                                                                  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Saint Stanislaus Cemetery</u>                                                                                                                                                                                                                                                     |                                                              | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u> |                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 19 1972</u>                                                                                                                                                                                                                                                                                                     |                         | 25B. NAME OF REGISTRAR<br><u>Andrew Johnston</u>                                                                                                            |                                                                  | 25C. FUNERAL DIRECTOR<br><u>Wm. Cook-Brooks Towson, Inc.</u><br>Towson, Md.                                                                                                                                                                                                                                                |                                                              |                                                                             |                                               |



No.

213-10-2423 A

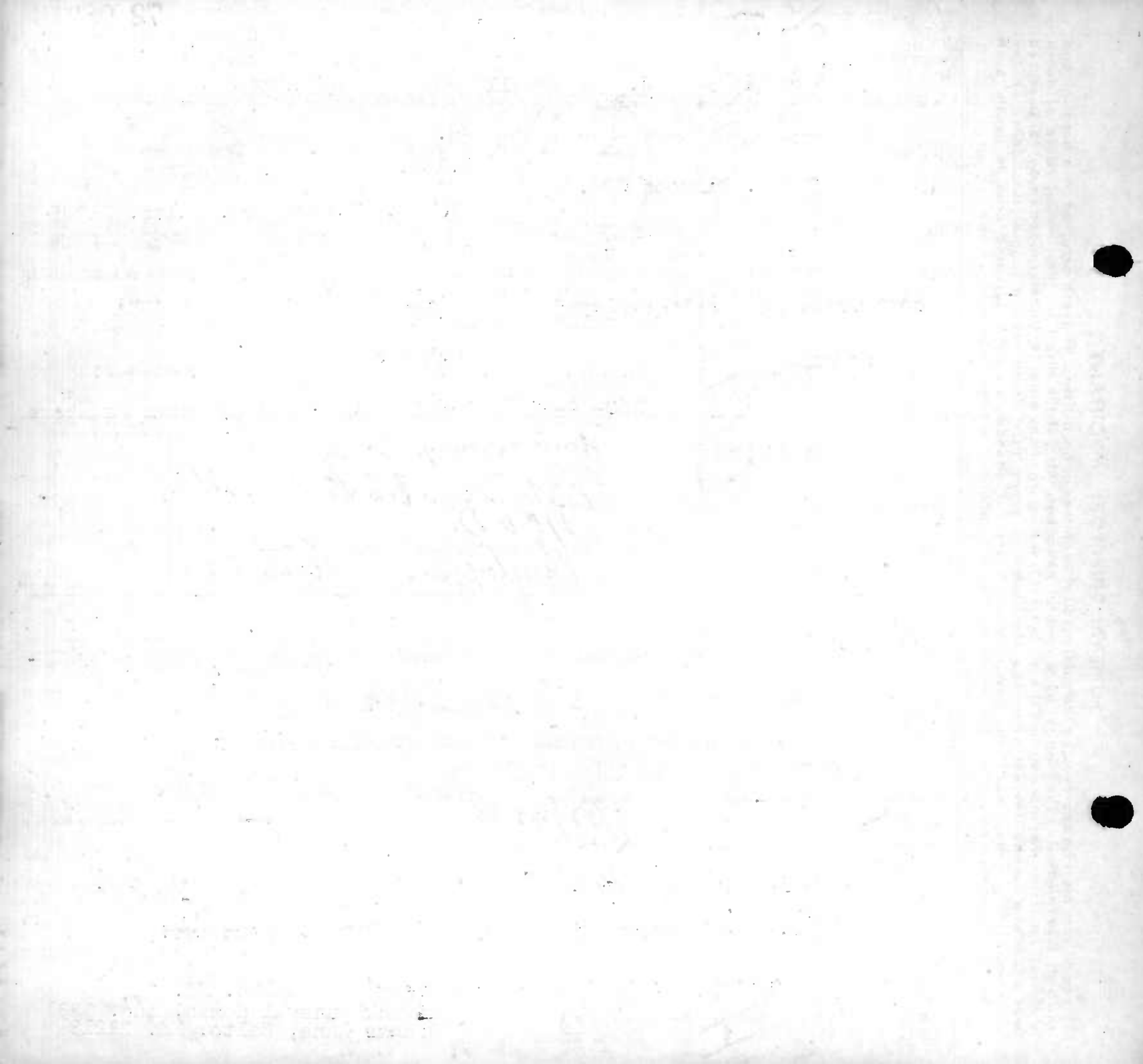
Edward A. Edwards, Jr.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                                  |                                | REG. NO. <u>72 08946</u>                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------|
| 72 08946                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                                  |                                | STATE OF MARYLAND - DIRECT                                               |
| BIRTH NO. <u>P-400</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 1. NAME OF DECEASED (Type or Print) <u>Russell J. Powell</u>                                                                                                     |                                |                                                                          |
| 2. DATE AND HOUR OF DEATH <u>9/15/72</u>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>701</u>                                |                                |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                         |                                |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>00 505 N. Ellwood Ave.</u>                                                                                                                                                                                                                                                                                                                                    |                  | E. STREET AND NUMBER <u>505 N. Ellwood Ave. Balto. 21205</u>                                                                                                     |                                |                                                                          |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> V DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH <u>9/3/03</u> | 9. AGE (In years last birthday) <u>69</u>                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>contractor</u>                                                                                                                                                                                                                                                                                                                                                                 |                  | 10B. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>                                                                                                           |                                | 11. BIRTHPLACE (State or foreign country) <u>Delaware</u>                |
| 13. FATHER'S NAME <u>unknown</u>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 14. MOTHER'S MAIDEN NAME <u>unknown</u>                                                                                                                          |                                |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>                                                                                                                                                                                                                                                                                                                                                            |                  | 16. SOCIAL SECURITY NO. <u>160-09-5986</u>                                                                                                                       |                                | 17. INFORMANT <u>Sophie Powell (wife)</u> ADDRESS <u>same as above</u>   |
| 18. <u>410.01</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Ante Corary. Infarction</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Arteriosclerotic Generalized</u><br><u>1/2 CVD.</u><br><u>Emphysema, Asthma</u> |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                |                                                                          |
| II                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                                  |                                |                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                                  |                                |                                                                          |
| 19A. DATE OF OPERATION <u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                 |                                | 20A. AUTOPSY? (Yes or No) <u>0</u>                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                         |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                           |                                | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Jan 1950</u> to <u>9/15</u> 19 <u>72</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>9/12/72</u> 19 <u>72</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.                                                                      |                  |                                                                                                                                                                  |                                |                                                                          |
| 23A. SIGNATURE <u>Melvin Jarowski M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 23B. DATE SIGNED <u>9/18/72</u>                                                                                                                                  |                                | 23C. PHYSICIAN'S NAME (Type) <u>Dr. Melvin Jarowski</u>                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 24B. DATE <u>9/18/72</u>                                                                                                                                         |                                | 24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>         |
| 24D. LOCATION (City, town, or county) <u>Balto. Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                       |                  | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 19 1972</u>                                                                                                               |                                |                                                                          |
| 25B. NAME OF REGISTRAR <u>Sidney H. Kohn</u>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 25C. FUNERAL DIRECTOR <u>Schimunk Funeral Homes, Inc.</u> ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>                                                      |                                |                                                                          |



72 08947 72 08947

Baltimore City Health Department  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Dorsey</b><br><b>Charles Berger</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>9 16 72 6:10 P.M.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Johns Hopkins Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>9 16 72 6:10 P.M.</b>                                                                          |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br><b>White</b>                                                                                                                             |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>841</b>              |  |
| 9. DATE OF BIRTH<br><b>7/8/12</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10. AGE (In years last birthday)<br><b>60</b>                                                                                                       |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Charles D. Berger</b>                                                                                            |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME<br><b>Clara LaBohn</b>                                                                                                     |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes WW 2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 17. SOCIAL SECURITY NO.<br><b>215-03-6472</b>                                                                                                       |  |
| 18. INFORMANT<br><b>Mrs. Mary McGarvey, dght.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS <b>21212 406 Makland Av</b>                                                                                                                 |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Sepsis</b>                                                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                        |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                    |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Market</b>                                           |  |
| 22D. TIME OF INJURY (APPROX.)<br>Month Day Year Hour<br><b>9 1 72 1:15 P.M.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Northeast Market</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22F. HOW DID INJURY OCCUR?<br><b>shot in chest</b>                                                                                                  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>William P. Mulloy, M.D.</b><br>EXAMINER'S NAME (Type)<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>9-17-72</b> |  |                                                                                                                                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br><b>9/20/72</b>                                                                                                                         |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Redeemer Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 19 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br><b>Audrey Ingham</b>                                                                                                      |  |
| 25C. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS<br><b>3331 Brehms Lane</b>                                                                                                                  |  |

VS 151-REV. 7/1/68

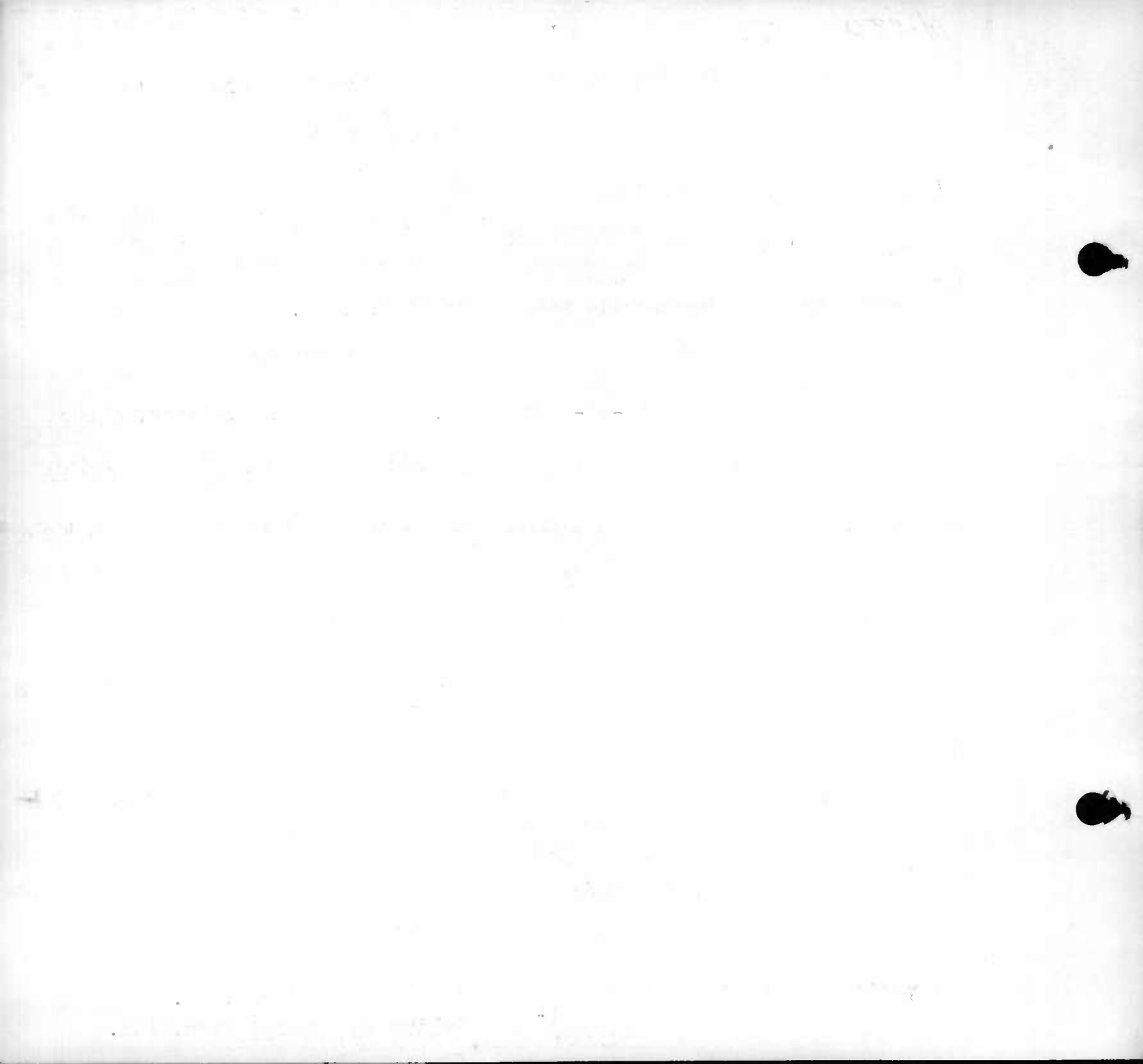
10-2-1972 - Letter from the Office of the Chief Medical Examiner,  
William P. Mulloy, M.D.  
Assistant Medical Examiner HRS

10-4-1972 - Letter from Daughter, Mary McGarvey requesting completion of  
Mother's Maiden name - LaBohn. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                                                                                                                                                                                                    |                                    | REG. NO. <u>72 08948</u>                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <u>ETHEL B. MASETH</u>                                                                                                                                                                                                                                                                          |                  | 2. DATE AND HOUR OF DEATH<br><u>9-17-72</u> <u>12:35 A.M.</u>                                                                                                                                                                                                                                                                      |                                    |                                                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                 |                  |                                                                                                                                                                                                                                                                                                                                    |                                    |                                                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>7 SINAI HOSPITAL</u>                                                                                                                                                                                                                                                                        |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>2642</u><br>C. CITY OR TOWN <u>BALTIMORE</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>4339 SHELDON AVENUE #6</u> |                                    |                                                                    |
| 5. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                        | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                        | 8. DATE OF BIRTH<br><u>4-11-03</u> | 9. AGE (In years last birthday) <u>69</u>                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Saleslady</u>                                                                                                                                                                                                                        |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Hochschild Kohn</u>                                                                                                                                                                                                                                                                        |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Md.</u> |
| 13. FATHER'S NAME<br><u>George Maseth</u>                                                                                                                                                                                                                                                                                              |                  | 14. MOTHER'S MAIDEN NAME<br><u>Emma Trager</u>                                                                                                                                                                                                                                                                                     |                                    |                                                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>216-28-1843</u>                                                                                                                                                                                                         |                  | 16. SOCIAL SECURITY NO.<br><u>216-28-1843</u>                                                                                                                                                                                                                                                                                      |                                    |                                                                    |
| 17. INFORMANT<br><u>Mrs. Bertha Koliska, sister, above</u>                                                                                                                                                                                                                                                                             |                  | ADDRESS                                                                                                                                                                                                                                                                                                                            |                                    |                                                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>RENAL FAILURE</u>                                                                                                             |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 DAYS</u>                                                                                                                                                                                                                                                                      |                                    |                                                                    |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                         |                  | (B) <u>HEPATO-RENAL SYNDROME</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>2 WKS.</u>                                                                                                                                                                                                                                               |                                    |                                                                    |
| (C) <u>? CARCINOMA OF LIVER</u>                                                                                                                                                                                                                                                                                                        |                  | <u>? MOS.</u>                                                                                                                                                                                                                                                                                                                      |                                    |                                                                    |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                 |                  | <u>G-I BLEEDING</u><br><u>3 WKS.</u>                                                                                                                                                                                                                                                                                               |                                    |                                                                    |
| 19A. DATE OF OPERATION<br><u>1965, 1969</u>                                                                                                                                                                                                                                                                                            |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>CARCINOMA OF PANCREAS</u>                                                                                                                                                                                                                                                   |                                    | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><u>NO</u>                                                                                                                                                                                                                                     |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>INJURY OCCUR?</u>                                                                                                                                                                                                                   |                                    |                                                                    |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                           |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                          |                                    |                                                                    |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                             |                  | 21G. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                        |                                    |                                                                    |
| 22. I certify that <u>X</u> (this hospital) attended the deceased from <u>9-5-72</u> to <u>9-17-72</u> that <u>X</u> (we) last saw the deceased alive on <u>9-17-72</u> and that <u>X</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) (did not) view the body after death. |                  |                                                                                                                                                                                                                                                                                                                                    |                                    |                                                                    |
| 23A. SIGNATURE<br><u>Ronald P. Byank, M.D.</u>                                                                                                                                                                                                                                                                                         |                  | 23B. DATE SIGNED<br><u>9-17-72</u>                                                                                                                                                                                                                                                                                                 |                                    | 23C. PHYSICIAN'S NAME (Type)<br><u>RONALD P. BYANK, M.D.</u>       |
| 23D. ADDRESS<br><u>SINAI HOSPITAL</u>                                                                                                                                                                                                                                                                                                  |                  | 23E. DATE REC'D BY HEALTH DEPT.<br><u>SEP 19 1972</u>                                                                                                                                                                                                                                                                              |                                    |                                                                    |
| 23F. NAME OF REGISTRAR<br><u>Sidney B. Watson</u>                                                                                                                                                                                                                                                                                      |                  | 23G. FUNERAL DIRECTOR<br><u>Schimunek Funeral Home, Inc.</u>                                                                                                                                                                                                                                                                       |                                    |                                                                    |
| 23H. ADDRESS<br><u>3331 Brehms Lane</u>                                                                                                                                                                                                                                                                                                |                  | 23I. DATE<br><u>9-19-72</u>                                                                                                                                                                                                                                                                                                        |                                    |                                                                    |



U-524 R-525

72 08949

STATE OF MARYLAND - PH-14  
BALTIMORE CITY HEALTH DEPARTMENT

72 08949

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print)<br>Joseph J. Ramaganno<br>Also known as --- Joseph Unkle                                                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month 9 Day 14 Year 72 Hour 12:45 P.M.                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>44 Union Memorial Hospital                                                                                                                                                                                                                            |  | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 14 Year 72 Hour 12:45 P.M.                                                                                                        |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br>White                                                                                                                                                         |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                              |  | C. CITY OR TOWN<br>Baltimore                                                                                                                                             |  |
| 9. DATE OF BIRTH<br>12/5/58                                                                                                                                                                                                                                                                                                                                                                                   |  | 10. AGE (In years last birthday)<br>13                                                                                                                                   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY?<br>John Ramaganno                                                                                                                           |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Student                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>Helen Burke                                                                                                                                  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.                                                                                                                                                  |  |
| 18. INFORMANT<br>Robert R. Unkle, step-father, above                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS                                                                                                                                                                  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>E876X<br>Inhalation of trichlorethylene and carbon tetrachloride                                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |  |
| 20A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Yard                                                                         |  |
| 22D. TIME OF INJURY (APPROX.)<br>9 14 72 A.                                                                                                                                                                                                                                                                                                                                                                   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                     |  |
| 22F. HOW DID INJURY OCCUR?<br>Accidentally inhaled trichlorethylene and carbon tetrachloride                                                                                                                                                                                                                                                                                                                  |  | 22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>rear yard of 1501 Argonne Drive 9-02                                                         |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                          |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>William P. Mulloy, M.D.                                                                                                                                                                                                                                                                                                                                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br>9/19/72                                                                                                                                                     |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Parkwood Cemetery                                                                                                                                                                                                                                                                                                                                                       |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.                                                                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 19 1972                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br>Audrey Whorton                                                                                                                                 |  |
| 25C. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane                                                                                                                                                                                                                                                                                                                                     |  | ADDRESS                                                                                                                                                                  |  |

11/17/72 - Letter from M.E.O., Dr. Wm. P. Mulloy.

ABP.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                       |                                                                                  |                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------------------|-----------------------|
| b-630                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 72 08950                                                                                                                                                    |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                           |                                       | REG. NO. 72 08950                                                                |                       |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             |  | STATE OF MARYLAND=DEATH                                                                                                                                                                                                                                                                                    |                                       |                                                                                  |                       |
| 1. NAME OF DECEASED<br>(Type or Print)<br>Brady, John T, Jr                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br>9/13/72 5:46 p. M.                                                                                                                                                                                                                                                            |                                       |                                                                                  |                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>31<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY BALTO<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 499 Fairview Avenue 21224 |                                       |                                                                                  |                       |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br>Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>8-7-85                                                                                                                                                                                                                                                                                 | 9. AGE (In years last birthday)<br>87 | If Under 1 Yr. Months                                                            | If Under 24 Hrs. Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Builder                                                                                                                                                                                                                                                                                                                                                                                   |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore Md                                                                                                                                                                                                                                                  |                                       | 12. CITIZEN OF WHAT COUNTRY?                                                     |                       |
| 13. FATHER'S NAME<br>John T. Brady                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                   |                                       |                                                                                  |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br>217-073156                                                                                                                                                                                                                                                                      |                                       | 17. INFORMANT<br>BCH-Records<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224 |                       |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                      |                                                                                                                                                             |  | (A) IMMEDIATE CAUSE<br>Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Pseudomonas pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                                                                                                                                       |                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>22 days                          |                       |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br>NO                                                                                                                                                                                                                                                                            |                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?             |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                   |                                       |                                                                                  |                       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                 |                                       |                                                                                  |                       |
| 22. I certify that (1) (this hospital) attended the deceased from 9/11 1972 to 9/13 1972, that (1) (we) lost the deceased on 9/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.                                                                                                                                                                                                  |                      |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                       |                                                                                  |                       |
| 23A. SIGNATURE<br>Robert Friedman MD                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |  | 23B. DATE SIGNED<br>9/13/72                                                                                                                                                                                                                                                                                |                                       |                                                                                  |                       |
| 23C. PHYSICIAN'S NAME (Type)<br>Dr. Robert Friedman, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             |  | 23D. ADDRESS<br>BCH - Baltimore, Maryland 21224                                                                                                                                                                                                                                                            |                                       |                                                                                  |                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      | 24B. DATE<br>9/16/72                                                                                                                                        |  | 24C. NAME OF CEMETERY or CREMATORY<br>Oaklawn Cemt                                                                                                                                                                                                                                                         |                                       | 24D. LOCATION (City, town, or county) (State)<br>Eastern Ave Balto Co Md         |                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 19 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 25B. NAME OF REGISTRAR<br>Sidney [illegible]                                                                                                                |  | 25C. FUNERAL DIRECTOR<br>Mitchell [illegible]                                                                                                                                                                                                                                                              |                                       | ADDRESS<br>Home                                                                  |                       |



| STATE OF MARYLAND - DHMH<br>BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                             |                                                                                                                                 |                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                             |                                                                                                                                 | REG. NO. 72 08951 |
| BIRTH NO. M-320 72 08951                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                             |                                                                                                                                 |                   |
| 1. NAME OF DECEASED<br>(Type or Print) Ruth G. Mathias                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 17 Year 72 Hour M. |                   |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>00 3426 Mayfield Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD Month 9 Day 17 Year 72 Hour 6:45 p. M.                                                                  |                   |
| 6. SEX female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                             | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 2633            |                   |
| 7. RACE White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |                   |
| 9. DATE OF BIRTH 6/25/91                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10. AGE (In years last birthday) 81                                                                                                                         | E. STREET AND NUMBER 3426 Mayfield Avenue                                                                                       |                   |
| 11. BIRTHPLACE (State or foreign country) N.Y.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY? U.S.                                                                                               |                   |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                             | 14B. KIND OF BUSINESS OR INDUSTRY Sinal Hosp                                                                                    |                   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                             | 17. SOCIAL SECURITY NO. 214-22-5986A                                                                                            |                   |
| 18. INFORMANT James C. Mathias                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                             | ADDRESS 1403 W. Cold Spring Lane                                                                                                |                   |
| 19. 412.4 CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                             |                                                                                                                                                             |                                                                                                                                 |                   |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                             | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |                   |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                             | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                        |                   |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                             | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                       |                   |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                             | 22F. HOW DID INJURY OCCUR?                                                                                                      |                   |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) DATE SIGNED 9/18/72<br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |                                                                                                                                                             |                                                                                                                                 |                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                             | 24B. DATE 9/20/72                                                                                                               |                   |
| 24C. NAME OF CEMETERY or CREMATORY Greenmount                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                             | 24D. LOCATION (City, town, or county) (State) Greenmount Balto. Md.                                                             |                   |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 19 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                             | 25B. NAME OF REGISTRAR Sidney Lipkovic                                                                                          |                   |
| 25C. FUNERAL DIRECTOR Paul E. Chenoweth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                             | ADDRESS 3rd. 3617 Chestnut Ave.                                                                                                 |                   |

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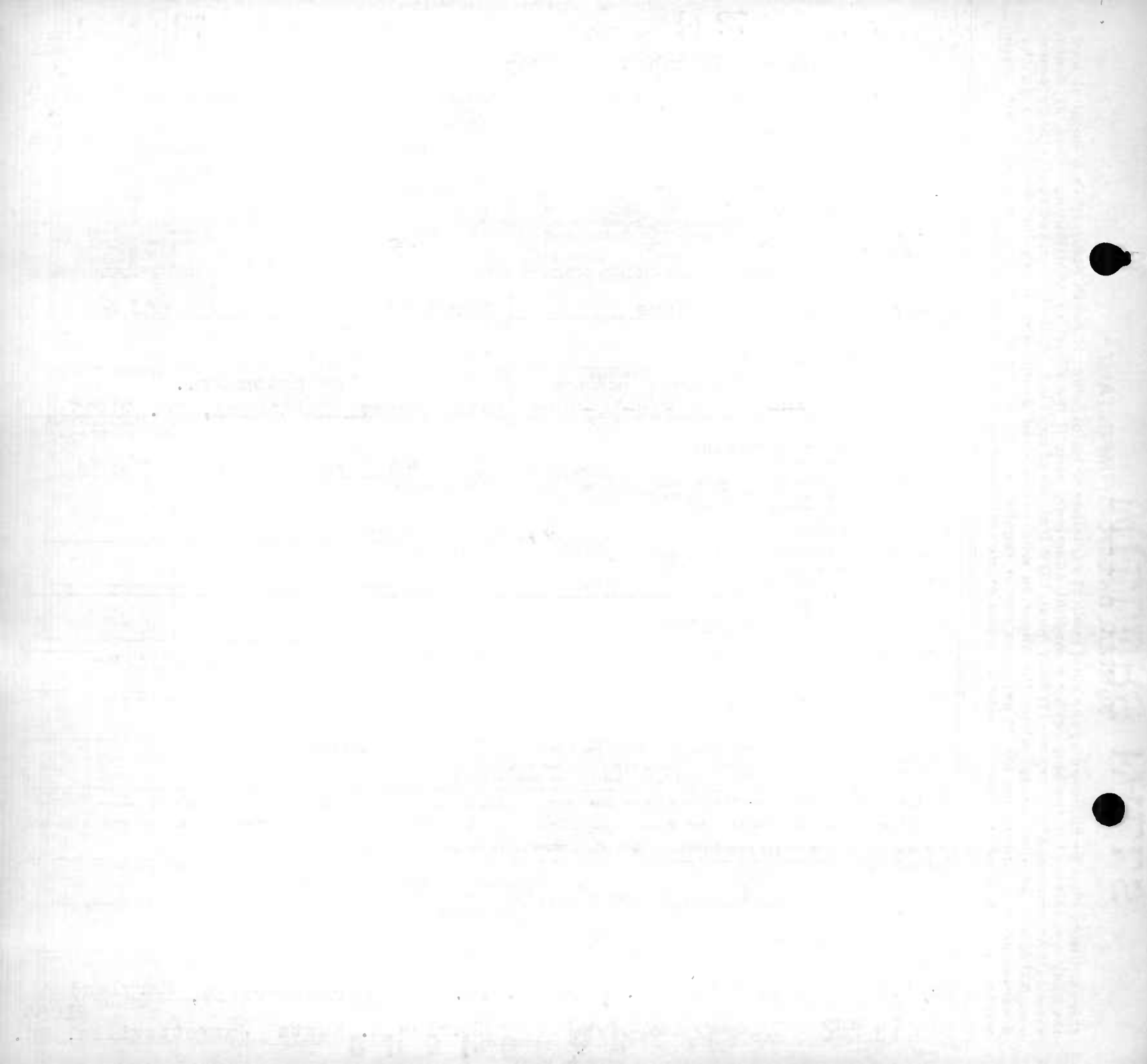
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <span style="float: right;">72 08952</span>                                                                                                                                                                                                                                              |  |                                                                                         |  | Baltimore City Health Department                                                                                                                            |  | REG. NO. <span style="float: right;">72 08952</span>                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                             |  |                                                                                         |  | 2. DATE AND HOUR OF DEATH                                                                                                                                   |  |                                                                                               |  |
| Mary Elizabeth Mabray                                                                                                                                                                                                                                                                              |  |                                                                                         |  | 9/16/72 1 430 A M.                                                                                                                                          |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                             |  |                                                                                         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE B. COUNTY                                                 |  |                                                                                               |  |
| Mary Elizabeth Mabray                                                                                                                                                                                                                                                                              |  |                                                                                         |  | Maryland Baltimore 1302                                                                                                                                     |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                               |  | (If not in hospital or institution, give street address or location)                    |  | C. CITY OR TOWN                                                                                                                                             |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Maryland General Hospital                                                                                                                                                                                                                                                                          |  | 830 Newington Avenue                                                                    |  | E. STREET AND NUMBER                                                                                                                                        |  |                                                                                               |  |
| 5. SEX                                                                                                                                                                                                                                                                                             |  | 6. RACE                                                                                 |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH                                                                              |  |
| Female                                                                                                                                                                                                                                                                                             |  | Black                                                                                   |  | 1/29/10                                                                                                                                                     |  | 9. AGE (In years last birthday) 62                                                            |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                       |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY?                                                                  |  |
| Housewife                                                                                                                                                                                                                                                                                          |  | Home                                                                                    |  | Maryland                                                                                                                                                    |  | USA                                                                                           |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                  |  |                                                                                         |  | 14. MOTHER'S MAIDEN NAME                                                                                                                                    |  |                                                                                               |  |
| Jesse Carey                                                                                                                                                                                                                                                                                        |  |                                                                                         |  | Molly Holland                                                                                                                                               |  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO.                                                                 |  | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                                                       |  |
| No                                                                                                                                                                                                                                                                                                 |  | 218-18-8865                                                                             |  | 830 Newington Ave.                                                                                                                                          |  | 21217                                                                                         |  |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                 |  |                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                                               |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                       |  |                                                                                         |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                         |  | 4 hrs                                                                                         |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                     |  |                                                                                         |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |  | Hypertension                                                                                  |  |
| (C)                                                                                                                                                                                                                                                                                                |  |                                                                                         |  |                                                                                                                                                             |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                             |  |                                                                                         |  |                                                                                                                                                             |  |                                                                                               |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                        |  | 20A. AUTOPSY (Yes or No)                                                                                                                                    |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 0                                                                                                                                                                                                                                                                                                  |  |                                                                                         |  | No                                                                                                                                                          |  |                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                      |  | 21E. INJURY OCCURRED                                                                    |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                               |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                        |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |  |                                                                                                                                                             |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 9/16 1972 to 7/16 1972<br>that (I) (me) last saw the deceased alive on 9/16 1972 and that (in my) (opinion) death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. |  |                                                                                         |  |                                                                                                                                                             |  |                                                                                               |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                     |  |                                                                                         |  | 23B. DATE SIGNED                                                                                                                                            |  |                                                                                               |  |
| George E. Labocco M.D. DEGREE                                                                                                                                                                                                                                                                      |  |                                                                                         |  | 9/16/72                                                                                                                                                     |  |                                                                                               |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                       |  |                                                                                         |  | 23D. ADDRESS                                                                                                                                                |  |                                                                                               |  |
| George E. Labocco M.D. DEGREE                                                                                                                                                                                                                                                                      |  |                                                                                         |  |                                                                                                                                                             |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                           |  | 24B. DATE                                                                               |  | 24C. NAME of CEMETERY or CREMATORY                                                                                                                          |  | 24D. LOCATION (City, town, or county) (State)                                                 |  |
| Burial                                                                                                                                                                                                                                                                                             |  | 9/19/1972                                                                               |  | St. James A.M.E.                                                                                                                                            |  | Jarrettsville, Maryland                                                                       |  |
| 25A. DATE RECD BY HEALTH DEPT.                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR                                                                  |  | 25C. FUNERAL DIRECTOR                                                                                                                                       |  | ADDRESS                                                                                       |  |
| SEP 19 1972                                                                                                                                                                                                                                                                                        |  | Sidney Johnston                                                                         |  | Charles E. Kurtz                                                                                                                                            |  | 21084 Jarrettsville, Md.                                                                      |  |



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Gerald Locke

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)FULL NAME OF  
HOSPITAL  
OR INSTITUTION

Maryland General Hospital

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years  
lost birthday)  
63If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

E. STREET AND NUMBER

2037 McCullough Street

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty metamorphosis of liver  
DUE TO, OR AS A CONSEQUENCE OF

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED.  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
9-7-7224A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9/12/72

24C. NAME OF CEMETERY or CREMATORY

Harmony Memorial Pk.

24D. LOCATION (City, town, or county)

Landover, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 19 1972

VS 151-REV. 1/1/68

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

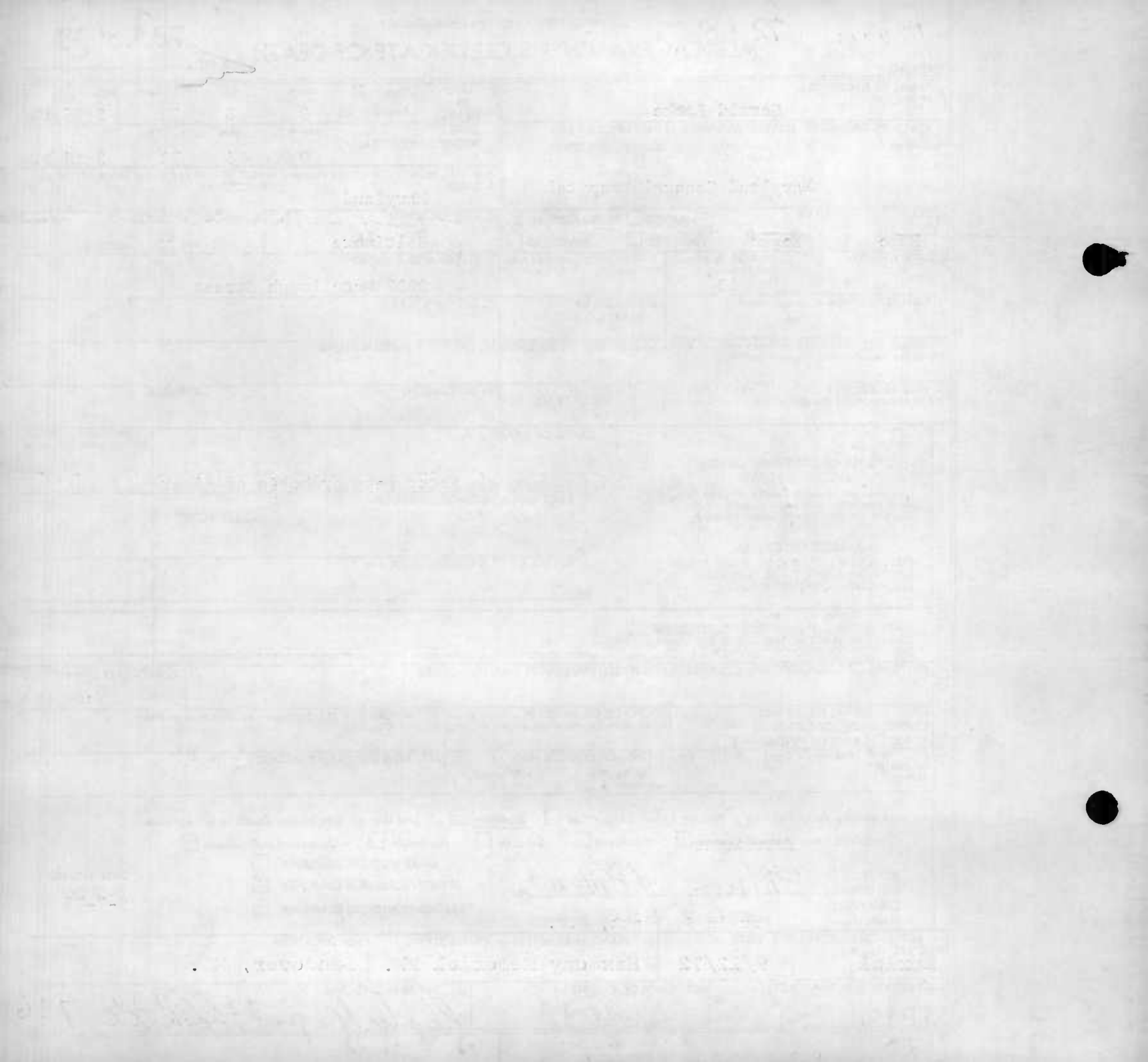
REG. NO.

72 08953

1403

325 P.H. S.W.  
Wash. D.C. 726



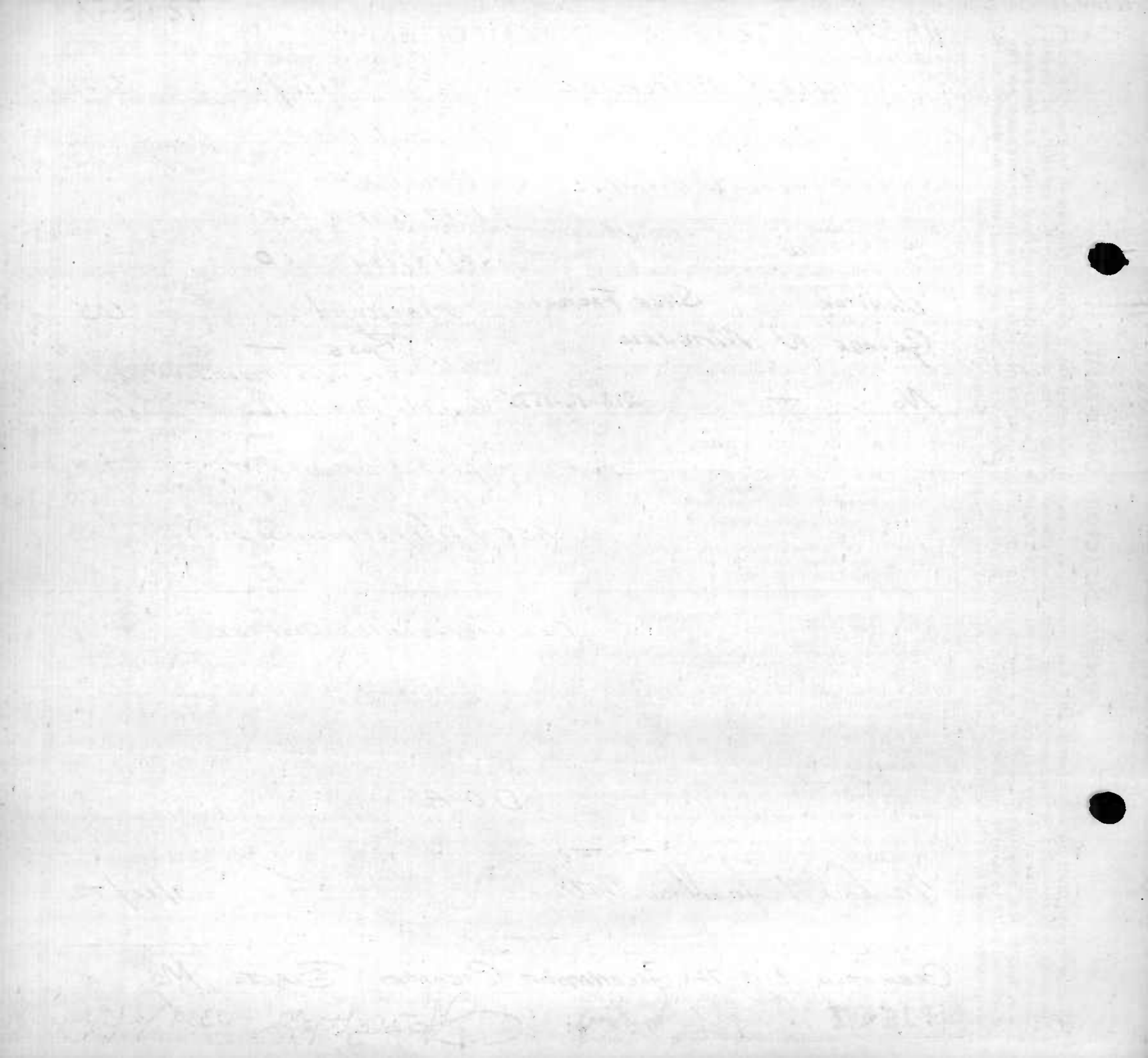




# FUNERAL DIRECTOR: IMPORTANT

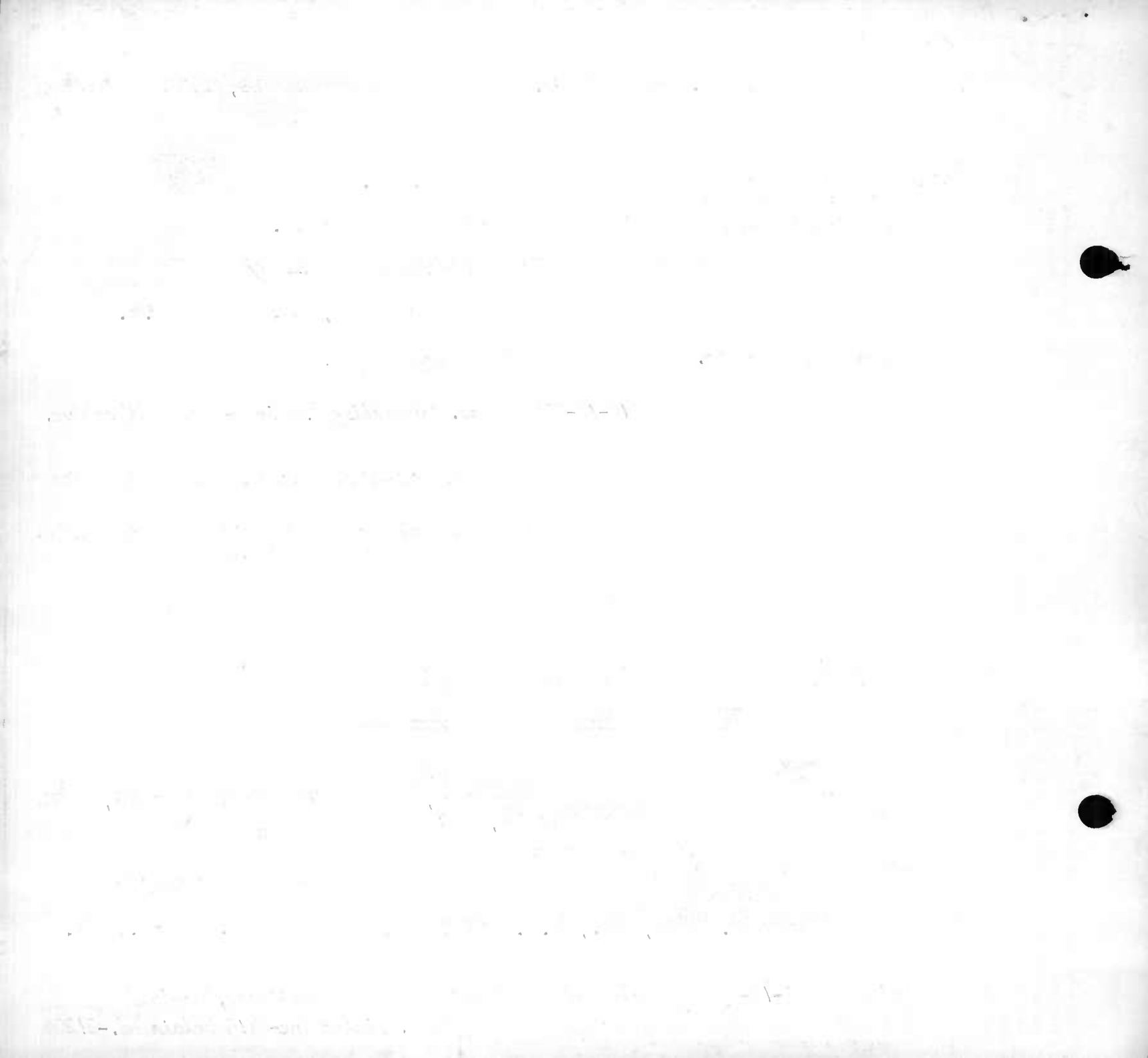
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>M-324</span> <span>72 08954</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>                                                                                                                                                                                                                                                                                                                                                                                     |                                                  | REG. NO. <span style="font-size: 1.2em;">72 08954</span>                                                                                                                                                                                                                                                                                                                                                                                              |
| BIRTH NO. <span style="font-size: 1.2em;">M-324</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                  | STATE OF <span style="font-size: 1.2em;">MARYLAND-DHMH</span>                                                                                                                                                                                                                                                                                                                                                                                         |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">HERBERT MITCHELL</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 2. DATE AND HOUR OF DEATH<br><div style="display: flex; justify-content: space-between;"> <span><span style="font-size: 1.2em;">9/11/72</span></span> <span><span style="font-size: 1.2em;">3:28 P.M.</span></span> </div>                                                                                                                                                                                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.2em;">UNION MEMORIAL Hospital</span>                                                                                                                                                                                                                                                                                                                                                                |                                                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">BALT</span><br>C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <span style="font-size: 1.2em;">1017 UNION AVE.</span> |
| 5. SEX <span style="font-size: 1.2em;">M</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE <span style="font-size: 1.2em;">W</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                      |
| 8. DATE OF BIRTH <span style="font-size: 1.2em;">10/19/1911</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                  | 9. AGE (In years last birthday) <span style="font-size: 1.2em;">60</span>                                                                                                                                                                                                                                                                                                                                                                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">VANITOR</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">SHOE FACTORY</span>                                                                                                                                                                                                                                                                                                                                                              |
| 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Maryland</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.</span>                                                                                                                                                                                                                                                                                                                                                                           |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">GEORGE W. MITCHELL</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 14. MOTHER'S MARDEN NAME<br><span style="font-size: 1.2em;">BOSE</span>                                                                                                                                                                                                                                                                                                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                  | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">218-16-1535</span>                                                                                                                                                                                                                                                                                                                                                                         |
| 17. INFORMANT <span style="font-size: 1.2em;">PREVIOUS RECORD FROM</span> ADDRESS <span style="font-size: 1.2em;">UMH AND</span><br><span style="font-size: 1.2em;">Gwelda Mitchell</span> <span style="font-size: 1.2em;">Same</span>                                                                                                                                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 18. <span style="font-size: 1.2em;">410.91</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><span style="font-size: 1.2em;">CEREBROVASCULAR DISEASE</span> |                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.2em;">0</span>                                                                                                                                                                                                                                                                                                                                                              |
| 19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                      |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                              |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">D.O.A.</span> 19 <span style="font-size: 1.2em;">19</span> to <span style="font-size: 1.2em;">19</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">19</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                              |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Michael Y. Faulkner MD</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">9/12/72</span>                                                                                                                                                                                                                                                                                                                                                                                    |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  | 23D. ADDRESS<br><span style="font-size: 1.2em;">-2334 Jefferson St</span>                                                                                                                                                                                                                                                                                                                                                                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">CREMATION</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  | 24B. DATE<br><span style="font-size: 1.2em;">9-14-72</span>                                                                                                                                                                                                                                                                                                                                                                                           |
| 24C. NAME of CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">GREENMOUNT CREMATORY</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">BALTO., MD</span>                                                                                                                                                                                                                                                                                                                                                    |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">SEP 19 1972</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                  | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Audrey W. [unclear]</span>                                                                                                                                                                                                                                                                                                                                                                  |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">[unclear]</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                  | ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                               |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>72 08955 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                                                                                                                                                                                   |                                     | REG. NO.<br>72 08955                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Louis F. Layfield Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | 2. DATE AND HOUR OF DEATH<br><b>September 16, 1972 9:45AM</b>                                                                                                                                                                                                                                                     |                                     |                                                                                   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>THE GOOD SAMARITAN HOSPITAL<br/>5601 Loch Raven Boulevard<br/>Baltimore, Maryland 21239</b>                                                                                                                                                                                                                                                                                                                                                                       |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE B. COUNTY<br><b>2642</b><br>C. CITY OR TOWN D. INSIDE CITY LIMITS?<br><b>Balto. Md. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b><br>E. STREET AND NUMBER<br><b>4524 Parkside Dr.</b> |                                     |                                                                                   |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                                                                                                                       | 8. DATE OF BIRTH<br><b>10-02-15</b> | 9. AGE (In years last birthday)<br><b>57 56</b>                                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bartender</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                 |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>                |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 13. FATHER'S NAME<br><b>Louis Layfield Sr.</b>                                                                                                                                                                                                                                                                    |                                     |                                                                                   |
| 14. MOTHER'S MAIDEN NAME<br><b>Barbara Carr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                             |                                     |                                                                                   |
| 16. SOCIAL SECURITY NO.<br><b>216-16-9085</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 17. INFORMANT ADDRESS<br><b>Mrs. Evangeline Layfield-6603 Walther Ave.</b>                                                                                                                                                                                                                                        |                                     |                                                                                   |
| 18. CAUSE OF DEATH<br><b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Intracranial metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Squamous carcinoma of the floor of the mouth</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                     |                                                                                                                                                                                                                                                                                                                   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 weeks</b><br><b>4 months</b> |
| 19A. DATE OF OPERATION<br><b>5/11/72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>primary tumor</b>                                                                                                                                                                                                                                          |                                     | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                            |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (necly medical examined) <b>no</b>                                                                                                                                                                                                                    |                                     |                                                                                   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br><b>xxx</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     | 21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)<br><b>xxx</b>                                                                                                                                                                                                                            |                                     |                                                                                   |
| 21D. TIME OF INJURY (Approx.)<br><b>xxx</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                         |                                     | 21F. HOW DID INJURY OCCUR?<br><b>xxx</b>                                          |
| 22. I certify that (1) (this hospital) attended the deceased from <b>August 9, 1972</b> to <b>September 16, 1972</b> and that (2) (my) last saw the deceased alive on <b>September 16, 1972</b> and that (3) (my) opinion death occurred on the date and hour and from the causes stated above. (4) (my) (did) (not) view the body after death.                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                                                                                                                                                                                   |                                     |                                                                                   |
| 23A. SIGNATURE<br><b>George H. Sack, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     | 23B. DATE SIGNED<br><b>9/16/72</b>                                                                                                                                                                                                                                                                                |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>George H. Sack, Jr., M.D.</b>                  |
| 23D. ADDRESS<br><b>5601 Loch Raven Blvd. Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                         |                                     |                                                                                   |
| 24B. DATE<br><b>9-19-72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 24C. NAME of CEMETERY or CREMATORY<br><b>Holy Redeemer Cemetery</b>                                                                                                                                                                                                                                               |                                     | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>       |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 19 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     | 25B. NAME OF REGISTRAR<br><b>John C. Miller Inc</b>                                                                                                                                                                                                                                                               |                                     | 25C. FUNERAL DIRECTOR ADDRESS<br><b>6415 Belair Rd. -21206</b>                    |



STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT

72 08956  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

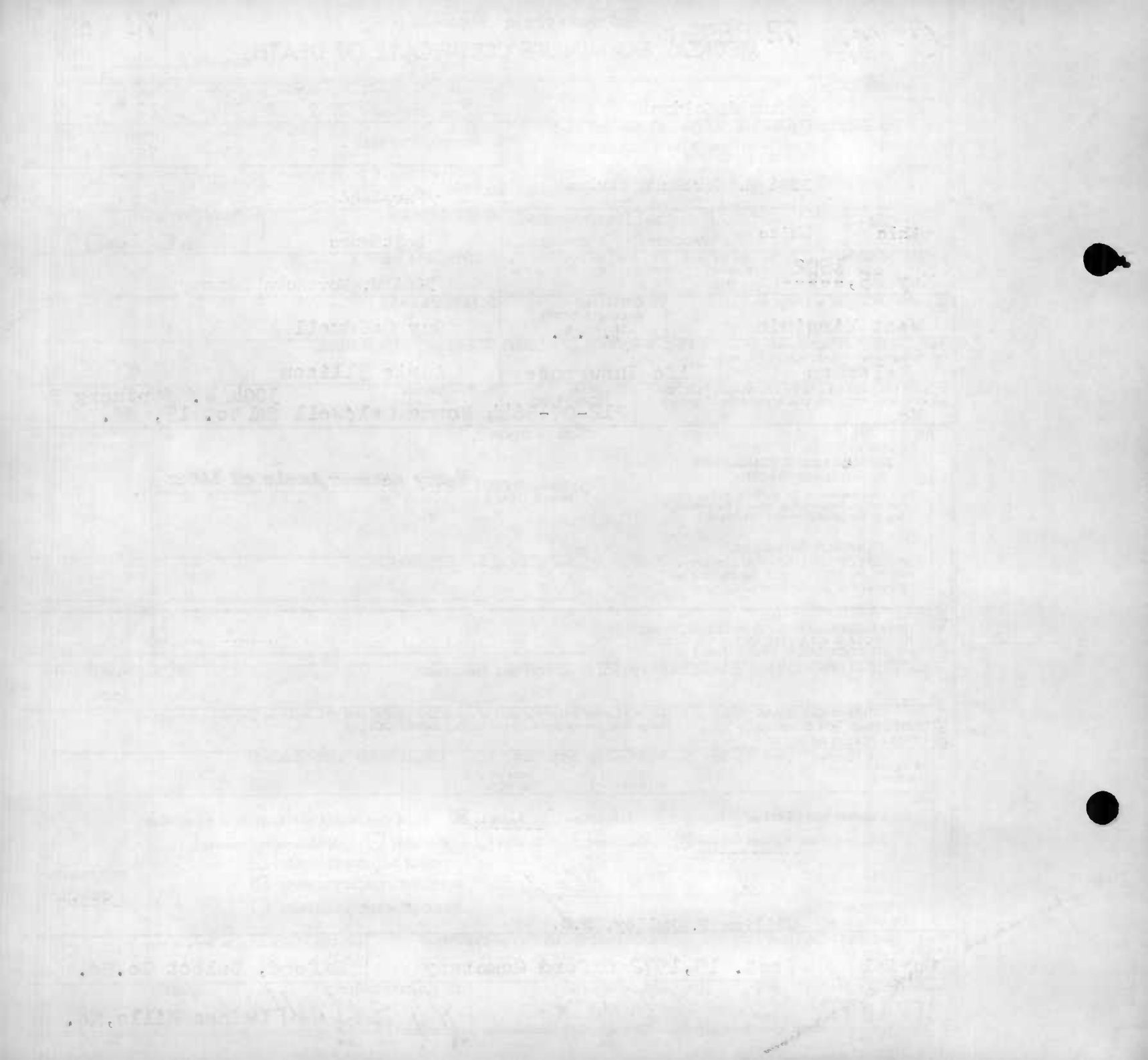
72 08956  
REG. NO. \_\_\_\_\_

**BIRTH NO.** \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |                                                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>1. NAME OF DECEASED</b><br>(Type or Print)<br><p style="text-align: center;">Gerald Caldwell</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | <b>2. DATE OF DEATH</b><br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><p style="text-align: center;">9 16 72 6:50 A.M.</p> |  |                                                                                                                                                         |  |
| <b>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><p style="text-align: center;">3004 W. Northern Parkway</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <b>3. DATE PRONOUNCED DEAD</b><br>Month Day Year Hour<br><p style="text-align: center;">9 16 72 6:50 A.M.</p>                                                                          |  |                                                                                                                                                         |  |
| <b>6. SEX</b><br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | <b>7. RACE</b><br>White                                                                                                                                                                |  | <b>8. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| <b>9. DATE OF BIRTH</b><br>May 25, 1902                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>10. AGE</b> (in years lost birthday)<br>70                                                                                                                                          |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br>West Virginia                                                                                       |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | <b>13. FATHER'S NAME</b><br>Guy Caldwell                                                                                                                                               |  |                                                                                                                                                         |  |
| <b>14A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Salesman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>14B. KIND OF BUSINESS OR INDUSTRY</b><br>Life Insurance                                                                                                                             |  | <b>15. MOTHER'S MAIDEN NAME</b><br>Adria Ellison                                                                                                        |  |
| <b>16. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>17. SOCIAL SECURITY NO.</b><br>212-09-5644                                                                                                                                          |  | <b>18. INFORMANT</b><br>3004 W. Northern P<br>Norma Caldwell Bal to. 15, Md.                                                                            |  |
| <b>19. CAUSE OF DEATH</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>(A) IMMEDIATE CAUSE Fatty metamorphosis of liver<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                              |  |                                                                                                                                                                                        |  |                                                                                                                                                         |  |
| <b>20A. DATE OF OPERATION</b><br>2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | <b>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br>21. AUTOPSY? (Yes or No)<br>Yes                                                                                             |  |                                                                                                                                                         |  |
| <b>22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.</b><br><input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | <b>22B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                        |  | <b>22C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                                                         |  |
| <b>22D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | <b>22E. INJURY OCCURRED.</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                      |  | <b>22F. HOW DID INJURY OCCUR?</b>                                                                                                                       |  |
| <b>23.</b><br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>W P Mulloy</i> M.D.<br>EXAMINER'S NAME (Type) William P. Mulloy, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |                                                                                                                                                                                        |  |                                                                                                                                                         |  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>24B. DATE</b><br>Sept. 19, 1972                                                                                                                                                     |  | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br>Oxford Cemetery                                                                                            |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br>Oxford, Talbot Co. Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br>SEP 19 1972                                                                                                                                  |  |                                                                                                                                                         |  |
| <b>25B. NAME OF REGISTRAR</b><br><i>Adrian Wharton</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | <b>25C. FUNERAL DIRECTOR</b><br>ADDRESS<br>H. J. Schudt Owings Mills, Md.                                                                                                              |  |                                                                                                                                                         |  |

DATE SIGNED  
9-16-72

VS 151-REV. 1/1/68





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| B-623                                                                                                                                                                                                                                                                                                                                 |  | 72 08957                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                 |  | 72 08957                                                                         |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | REG. NO.                                                                                                                                         |  |                                                                                  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>EDWARD JAMES BRIGHT</i>                                                                                                                                                                                                                                                                     |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><i>9/13/72</i> <i>9:40 AM</i>                                                                                       |  |                                                                                  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                            |  |                                                                                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>MD GENERAL HOSPITAL</i><br><i>48 Md Gen Hosp</i>                                                                                                                                                                                                                                           |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                      |  | A. STATE<br><i>MD</i>                                                                                                                            |  | B. COUNTY<br><i>BALTO.</i>                                                       |  |
| 5. SEX<br><i>MALE</i>                                                                                                                                                                                                                                                                                                                 |  | 6. RACE<br><i>WHITE</i>                                                                                   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>9-2-1901</i>                                              |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>RETIRED</i>                                                                                                                                                                                                                         |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Inherent Time Co.</i>                                             |  | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md.</i>                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                    |  |
| 13. FATHER'S NAME<br><i>Thomas Howard Bright</i>                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><i>Laura Rogers</i>                                                                                                  |  |                                                                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>                                                                                                                                                                                                                 |  | 16. SOCIAL SECURITY NO.<br><i>217-22-1013</i>                                                             |  | 17. INFORMANT<br><i>Wm. E. Lighted Bright</i>                                                                                                    |  | 18. ADDRESS<br><i>115 Glyndon Drive, Baltimore, Md.</i>                          |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>162.1</i><br><i>Carcinoma of lung</i>                                                                                        |  |                                                                                                           |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 months</i>                  |  |
| 20. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                    |  |                                                                                                           |  | (B) <i>metastasis to liver</i><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                |  |                                                                                  |  |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                  |  |                                                                                                           |  | (C) _____                                                                                                                                        |  |                                                                                  |  |
| 19A. DATE OF OPERATION<br><i>0</i>                                                                                                                                                                                                                                                                                                    |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                                                                                           |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?             |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)                                                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                      |  |                                                                                  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                          |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                       |  |                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1960</i> 19 _____ to <i>August</i> 19 _____ that (I) (we) last saw the deceased alive on <i>9/12/72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                  |  |                                                                                  |  |
| 23A. SIGNATURE<br><i>W. H. Townsend M.D.</i>                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 23B. DATE SIGNED<br><i>9/13/72</i>                                                                                                               |  |                                                                                  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>W. H. TOWNSEND M.D.</i>                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | 23D. ADDRESS<br><i>14 E. Eager St. Baltimore, Md.</i>                                                                                            |  |                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><i>SEP 15 1972</i>                                                                           |  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Greenwood Cemetery</i>                                                                                  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Pikesville Baltimore Md.</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>SEP 19 1972</i>                                                                                                                                                                                                                                                                                 |  | 25B. NAME OF REGISTRAR<br><i>Frank H. Newell</i>                                                          |  | 25C. FUNERAL DIRECTOR<br><i>Frank H. Newell</i>                                                                                                  |  | ADDRESS<br><i>Pikesville, Md.</i>                                                |  |

1871

The above named party  
has been appointed  
to the office of  
the clerk of the court

and the same has been  
filed for record



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

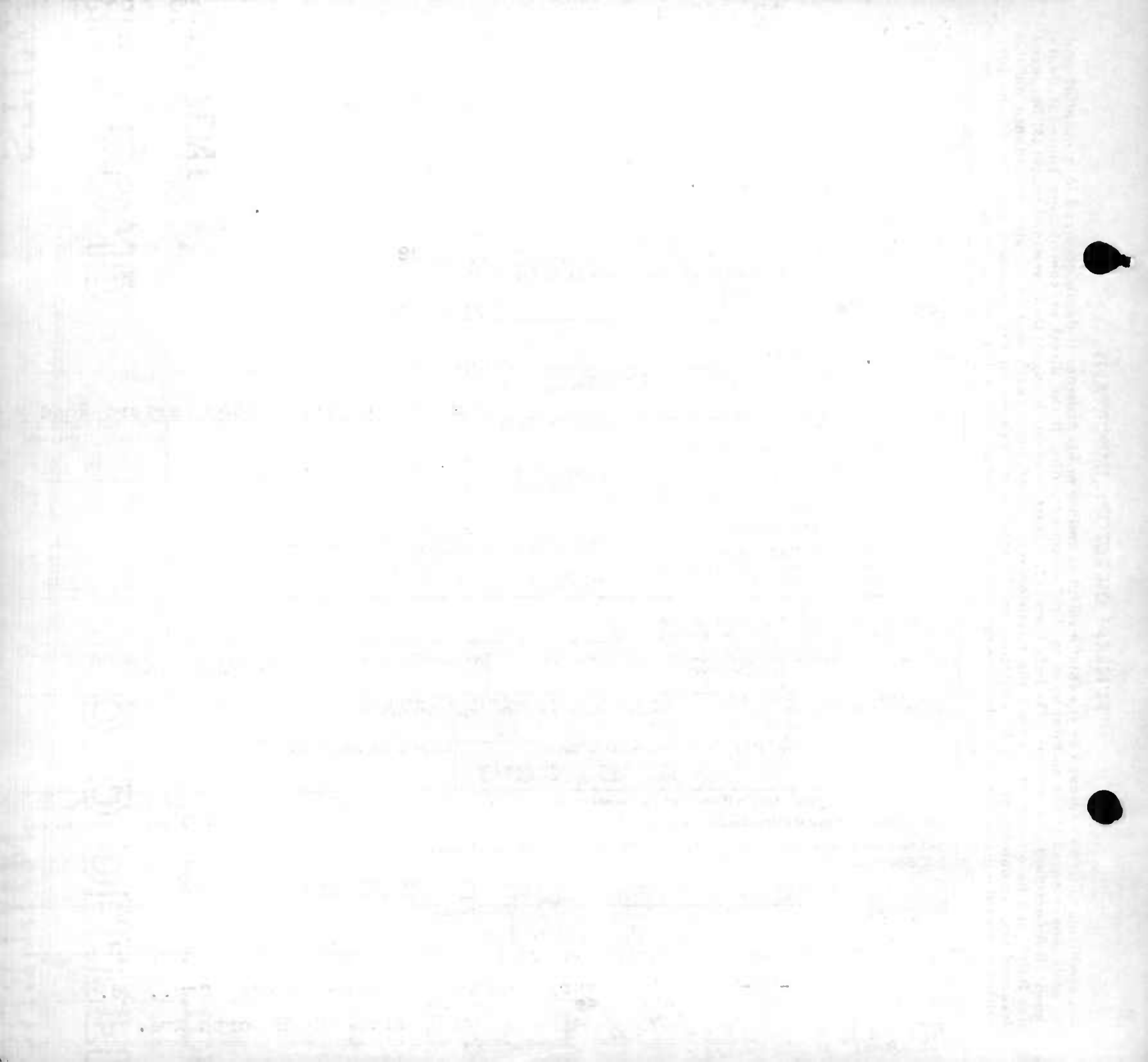
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                        |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                            | REG. NO. 72 08958                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| <b>W-425</b><br><b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <b>ALAN WILSON</b>                                                                                                                                                                                                                                                                                                    |                                | <b>72 08958 CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                            |                                                                                                                                      |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><b>Johns Hopkins Hospital</b>                                                                                                                                                                                  |                                | <b>2. DATE AND HOUR OF DEATH</b><br><b>Sept 17, 1972</b> <b>8:00 AM</b> M.<br><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> <b>B. COUNTY</b><br><b>NEW JERSEY</b><br><b>127</b><br><b>C. CITY OR TOWN</b> <b>D. INSIDE CITY LIMITS?</b><br><b>PITMAN</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b><br><b>10 ADAMS AVE</b> |                                            |                                                                                                                                      |
| <b>5. SEX</b><br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                            | <b>6. RACE</b><br><b>WHITE</b> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                                                                                                                              | <b>8. DATE OF BIRTH</b><br><b>04-22-65</b> | <b>9. AGE</b> (In years last birthday) <b>7</b><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                         |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Student</b>                                                                                                                                                                                                                                                                                    |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>11. BIRTHPLACE</b> (State or foreign country) <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>Rochester, New York</b> <b>USA</b>                                                                                                                                                                                                                                                                            |                                            |                                                                                                                                      |
| <b>13. FATHER'S NAME</b><br><b>JOSEPH W. WILSON</b>                                                                                                                                                                                                                                                                                                                                                     |                                | <b>14. MOTHER'S MAIDEN NAME</b><br><b>NORMA KENT</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                            |                                                                                                                                      |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                         |                                | <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>ADDRESS</b><br><b>None</b> <b>Kelley Funeral Home, Pitman, New Jersey.</b>                                                                                                                                                                                                                                                                                                                    |                                            |                                                                                                                                      |
| <b>18. CAUSE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                               |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                            |                                                                                                                                      |
| <b>I</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                          |                                | <b>(A) IMMEDIATE CAUSE</b> <b>Hypoxic Brain Damage</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(B) Shock and Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>(C) Correction of Coarctation of Aorta.</b>                                                                                                                                                                                                                                    |                                            |                                                                                                                                      |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                                                    |                                | <b>Approximate Interval Between Onset and Death</b><br><b>7 days</b><br><b>7 days</b><br><b>7 days</b><br><b>Birth</b>                                                                                                                                                                                                                                                                                                                               |                                            |                                                                                                                                      |
| <b>19A. DATE OF OPERATION</b><br><b>Sept 11, 1972</b>                                                                                                                                                                                                                                                                                                                                                   |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><b>Coarctation of Aorta</b>                                                                                                                                                                                                                                                                                                                                                               |                                            | <b>20A. AUTOPSY?</b> (Yes or No) <b>YES</b><br><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>NO</b> |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                        |                                | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)<br><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br><b>21F. HOW DID INJURY OCCUR?</b>                                                                                                             |                                            |                                                                                                                                      |
| <b>22. I certify that (1) (this hospital) attended the deceased from</b> <b>Sept 9</b> <b>19 72</b> <b>to</b> <b>Sept 17</b> <b>19 72</b> ,<br><b>that (1) (we) last saw the deceased alive on</b> <b>Sept 16</b> <b>19 72</b> <b>and that in (2) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b> |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                            |                                                                                                                                      |
| <b>23A. SIGNATURE</b><br><b>J. Alex Haller, M.D.</b>                                                                                                                                                                                                                                                                                                                                                    |                                | <b>Attending Phys.</b> <input checked="" type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                      |                                            | <b>23B. DATE SIGNED</b><br><b>Sept 17, 1972</b>                                                                                      |
| <b>23C. PHYSICIAN'S NAME (Type)</b><br><b>J. ALEX HALLER</b>                                                                                                                                                                                                                                                                                                                                            |                                | <b>23D. ADDRESS</b><br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                            |                                                                                                                                      |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                        |                                | <b>24B. DATE</b><br><b>9/20/72.</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                            | <b>24C. NAME OF CEMETERY or CREMATORY</b><br><b>Manahath Cemetery</b>                                                                |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>SEP 19 1972</b>                                                                                                                                                                                                                                                                                                                                            |                                | <b>25B. NAME OF REGISTRAR</b><br><b>Sidney B. Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                            | <b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b><br><b>Leonard J. Ruck, Inc. Bal to. Md. 21214</b>                                        |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Glassboro, New Jersey.</b>                                                                                                                                                                                                                                                                                                                   |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                            |                                                                                                                                      |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                                                                                                                               |                                                                                       |                                                       |                                                                                    |                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------|
| B-623                                                                                                                                                                                                                                                                                                                                          |                  | 72 08959                                                                                                                                                    |                                                                                                                               | BALTIMORE CITY HEALTH DEPARTMENT                                                      |                                                       | 72 08959                                                                           |                              |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                      |                  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                                                                                                                               | 2. DATE AND HOUR OF DEATH                                                             |                                                       | REG. NO.<br>STATE OF MARYLAND-DEN                                                  |                              |
|                                                                                                                                                                                                                                                                                                                                                |                  | CLARINE BARKSDALE                                                                                                                                           |                                                                                                                               | 9/17/72 11:10 P.M.                                                                    |                                                       |                                                                                    |                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                                                                                                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                                       |                                                                                    |                              |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>JOHNS HOPKINS HOSPITAL<br>BALTIMORE, MD. 21205                                                                                                                                                                                 |                  |                                                                                                                                                             |                                                                                                                               | A. STATE<br>MARYLAND                                                                  |                                                       | B. COUNTY                                                                          |                              |
| 33                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                                                                                                               | C. CITY OR TOWN<br>BALTIMORE                                                          |                                                       | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                              |
|                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                                                                                                                               | E. STREET AND NUMBER<br>2650 HARFORD RD.                                              |                                                       |                                                                                    |                              |
| 5. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                               | 6. RACE<br>NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>8/22/22                                                                                                   | 9. AGE (in years last birthday)<br>50                                                 | 10. Under 1 Yr. Months: Days: Hours: Min.             | 11. Under 24 Hrs. Hours: Min.                                                      |                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                                                                       |                  |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                                                       | 11. BIRTHPLACE (State or foreign country)<br>Virginia |                                                                                    | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME<br>John L. Johnson                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br>Goodie                                                                                            |                                                                                       |                                                       |                                                                                    |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                       |                  |                                                                                                                                                             | 16. SOCIAL SECURITY NO.                                                                                                       |                                                                                       | 17. INFORMANT<br>Russell Barksdale 2650 Harford Road  |                                                                                    |                              |
| 18. 4360 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST<br>(B) BRAINSTEM CVA<br>(C) HYPERTENSION |                                                                                       |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 minutes<br>16 Hours<br>19 yrs    |                              |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                                                                                                               |                                                                                       |                                                       |                                                                                    |                              |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                         |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                               | 20A. AUTOPSY? (Yes or No)                                                             |                                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                          |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                                       |                                                                                    |                              |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                      |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                               | 21F. HOW DID INJURY OCCUR?                                                            |                                                       |                                                                                    |                              |
| 22. I certify that (I) (this hospital) attended the deceased from 9/17/72 1972 to 9/17/72 1972 that (I) (we) last saw the deceased alive on 9/17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                 |                  |                                                                                                                                                             |                                                                                                                               |                                                                                       |                                                       |                                                                                    |                              |
| 23A. SIGNATURE<br>John B. Welch M.D., Ph.D.                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |                                                                                                                               | 23B. DATE SIGNED<br>9/17/72                                                           |                                                       | 23C. PHYSICIAN'S NAME (Type)<br>JOHN B. WELCH M.D. Ph.D.                           |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                                                                                                               | 24B. DATE<br>9-22-72                                                                  |                                                       | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt Calvary Cemetery                          |                              |
| 24D. LOCATION<br>Anne Arundel Cty., Md.                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                                                                                                                               | 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 19 1972                                        |                                                       | 25B. NAME OF REGISTRAR<br>Sidney Johnson                                           |                              |
| 25C. FUNERAL DIRECTOR<br>Wm G March 928 E North Ave.                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             |                                                                                                                               |                                                                                       |                                                       |                                                                                    |                              |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                  |              |                                                                                                                                                             |                              | 72 08960                                                                                                  |                                |                                 |                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------|---------------------------------------|
| BIRTH NO. R-324                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                              | 72 08960                                                                                                  |                                |                                 |                                       |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                            |              |                                                                                                                                                             |                              | 2. DATE AND HOUR OF DEATH                                                                                 |                                |                                 |                                       |
| Anita Radcliffe (Radcliffe)                                                                                                                                                                                                                                                                       |              |                                                                                                                                                             |                              | 9/16/72 10:30 AM                                                                                          |                                |                                 |                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                            |              |                                                                                                                                                             |                              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                     |                                |                                 |                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>33                                                                                                                                                                                                                                                        |              |                                                                                                                                                             |                              | A. STATE<br>1604 E. LANVALE ST. 806                                                                       |                                |                                 |                                       |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>JOHNS HOPKINS HOSPITAL<br>BALTIMORE, MD. 21205                                                                                                                                                                            |              |                                                                                                                                                             |                              | B. COUNTY<br>BALTIMORE, MD.                                                                               |                                |                                 |                                       |
|                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                              | C. CITY OR TOWN<br>BALTIMORE, MD.                                                                         |                                |                                 |                                       |
|                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |                                |                                 |                                       |
|                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                              | E. STREET AND NUMBER<br>1604 E. LANVALE ST.                                                               |                                |                                 |                                       |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                       | 6. RACE<br>N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>05/10/12 | 9. AGE (In years lost birthday)<br>60                                                                     | 10. UNDER 1 Yr. Months<br>Days | 11. UNDER 24 Hrs. Hours<br>Min. | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                                                                                                                                                                                          |              |                                                                                                                                                             |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br>-                                                                    |                                |                                 |                                       |
| 13. FATHER'S NAME<br>Celia Barker Jr.                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |                              | 14. MOTHER'S MAIDEN NAME<br>Patti West                                                                    |                                |                                 |                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                    |              |                                                                                                                                                             |                              | 16. SOCIAL SECURITY NO.                                                                                   |                                |                                 |                                       |
|                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                              | 17. INFORMANT<br>Anita R. Radcliffe 1301 N. Montford Ave                                                  |                                |                                 |                                       |
| 18. 441.91                                                                                                                                                                                                                                                                                        |              |                                                                                                                                                             |                              | ADDRESS                                                                                                   |                                |                                 |                                       |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                |              |                                                                                                                                                             |                              | CAUSE OF DEATH                                                                                            |                                |                                 |                                       |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                    |              |                                                                                                                                                             |                              | (A) IMMEDIATE CAUSE<br>Sepsis → yeast E. coli pseudomonas                                                 |                                |                                 |                                       |
|                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                              | (B) infected aortic aneurysm                                                                              |                                |                                 |                                       |
|                                                                                                                                                                                                                                                                                                   |              |                                                                                                                                                             |                              | (C) infected wounds @ groin @ flank                                                                       |                                |                                 |                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                            |              |                                                                                                                                                             |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 hrs<br>1 month<br>2 weeks                              |                                |                                 |                                       |
| 19A. DATE OF OPERATION<br>8/25/72                                                                                                                                                                                                                                                                 |              |                                                                                                                                                             |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>abd. mass - aneurysm                                  |                                |                                 |                                       |
| 20A. AUTOPSY? (Yes or No)<br>YES                                                                                                                                                                                                                                                                  |              |                                                                                                                                                             |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO                                   |                                |                                 |                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>N/A                                                                                                                                                                                                      |              |                                                                                                                                                             |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                |                                 |                                       |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                       |              |                                                                                                                                                             |                              |                                                                                                           |                                |                                 |                                       |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                      |              |                                                                                                                                                             |                              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                |                                 |                                       |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                        |              |                                                                                                                                                             |                              |                                                                                                           |                                |                                 |                                       |
| 22. I certify that (I) (this hospital) attended the deceased from 9/1/72 to 9/16/72 that (I) (we) last saw the deceased alive on 9/16/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |              |                                                                                                                                                             |                              |                                                                                                           |                                |                                 |                                       |
| 23A. SIGNATURE<br>Ronald Hantman M.D.                                                                                                                                                                                                                                                             |              |                                                                                                                                                             |                              | 23B. DATE SIGNED<br>9/16/72                                                                               |                                |                                 |                                       |
| 23C. PHYSICIAN'S NAME (Type)<br>Ronald Hantman, M.D.                                                                                                                                                                                                                                              |              |                                                                                                                                                             |                              | 23D. ADDRESS<br>JOHNS HOPKINS HOSPITAL<br>601 N. BROADWAY 21205                                           |                                |                                 |                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                |              |                                                                                                                                                             |                              | 24B. DATE<br>9-20-72                                                                                      |                                |                                 |                                       |
| 24C. NAME OF CEMETERY OR CREMATORY<br>Balti. National Cem                                                                                                                                                                                                                                         |              |                                                                                                                                                             |                              | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.                                           |                                |                                 |                                       |
| 25A. DATE REG'D BY HEALTH DEPT.<br>SEP 19 1972                                                                                                                                                                                                                                                    |              |                                                                                                                                                             |                              | 25B. NAME OF REGISTRAR<br>Sidney H. Hantman                                                               |                                |                                 |                                       |
| 25C. FUNERAL DIRECTOR<br>E. H. H. Hantman                                                                                                                                                                                                                                                         |              |                                                                                                                                                             |                              | 25D. ADDRESS<br>29 N. CAROLINE ST.                                                                        |                                |                                 |                                       |

DATE 3-11-41  
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                             | REG. NO. 08961                                                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--|
| 5-530 72 08961                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                             | CERTIFICATE OF DEATH                                                                                                                       |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                |  | 1. NAME OF DECEASED<br>(Type or Print) <b>JOSEPHINE SMITH</b>                                                                                                                                                                                                                                                                           |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>Sept 15, 72 3 15 AM</b>                                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>South Baltimore General Hospital 43</b>                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2301</b> |  |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                          |  | 6. RACE <b>N</b>                                                                                                                                                                                                                                                                                                                        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>July 29, 1925</b>                                                                                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>                                                                                                                                                                                                                               |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                       |                                                                                                                                                             | 9. AGE (In years lost birthday) <b>47 yrs</b>                                                                                              |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                             |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                            |                                                                                                                                                             | 13. FATHER'S NAME<br><b>HARDY SMITH</b>                                                                                                    |  |
| 14. MOTHER'S MAIDEN NAME<br><b>DORA</b>                                                                                                                                                                                                                                                                                                  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                |                                                                                                                                                             | 16. SOCIAL SECURITY NO.                                                                                                                    |  |
| 17. INFORMANT<br><b>Lucy Robinson</b>                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br><b>2717 Winchester St</b>                                                                                                                                                                                                                                                                                                    |                                                                                                                                                             | 18. CAUSE OF DEATH                                                                                                                         |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | (A) IMMEDIATE CAUSE <b>septicaemia</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                               |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                               |  |
| (B) <b>Ca. ovary, hepatic metastases,</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                             |  | (C) <b>abdominal abscess</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                                             |                                                                                                                                            |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                             |                                                                                                                                            |  |
| 19A. DATE OF OPERATION<br><b>Sept 10, 72</b>                                                                                                                                                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ca. ovary</b>                                                                                                                                                                                                                                                                    |                                                                                                                                                             | 20A. AUTOPSY? (Yes or No)                                                                                                                  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                     |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                          |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                 |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                               |                                                                                                                                                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |  |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                               |  | 22. I certify that (I) (this hospital) attended the deceased from <b>Aug 19 1972</b> to <b>Sept 15 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept 15 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                                                                                                                             |                                                                                                                                            |  |
| 23A. SIGNATURE<br><b>Rashid M. Gill</b>                                                                                                                                                                                                                                                                                                  |  | 23B. DATE SIGNED<br><b>Sept 15, 72</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                                             | 23C. PHYSICIAN'S NAME (Type)<br><b>GILL</b>                                                                                                |  |
| 23D. ADDRESS<br><b>3001 S. Hanover St Baltimore 21230</b>                                                                                                                                                                                                                                                                                |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                               |                                                                                                                                                             |                                                                                                                                            |  |
| 24B. DATE<br><b>9-19-72</b>                                                                                                                                                                                                                                                                                                              |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>M.T. CALVARY Cem.</b>                                                                                                                                                                                                                                                                          |                                                                                                                                                             | 24D. LOCATION (City, town, or county) (State)<br><b>A.A. Co. MD</b>                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 19 1972</b>                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR<br><b>Lidney</b>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><b>BROWN</b>                                                                                                      |  |
| 25D. ADDRESS<br><b>123 W. Montgomer</b>                                                                                                                                                                                                                                                                                                  |  | VS 150-REV. 1/1/68                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                             |                                                                                                                                            |  |



1031 PEACH ST



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 18962

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| BIRTH NO. 72 18962                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | STATE OF MARYLAND - DHEH                                                                                                                                    |                                       |
| 1. NAME OF DECEASED<br>(Type or Print) ALICE JONES RANDALL                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 2. DATE AND HOUR OF DEATH<br>9/17/72 8 P. M.                                                                                                                |                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>90 LONG GREEN NURSING HOME                                                                                                                                                                                                                                                                                                                   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY 1307                                |                                       |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>July 21, 1983     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired - Secty                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Secretarial                                                                                                            | 9. AGE (In years last birthday)<br>89 |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                         |                                       |
| 13. FATHER'S NAME<br>William Dilworth Randall                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 14. MOTHER'S MAIDEN NAME<br>Isabel Jones                                                                                                                    |                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 16. SOCIAL SECURITY NO.<br>212-32-2851                                                                                                                      |                                       |
| 17. INFORMANT: Sister-<br>Helen R. Hardy, 3931 Keswick, Balto., Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | ADDRESS                                                                                                                                                     |                                       |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Carcinoma of esophagus<br>I<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>ASCVD. |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 mo<br>2 yr                                                                                                |                                       |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                       |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |                                       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                 |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                       |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                   |                                       |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |                                       |
| 22. I certify that (I) (this hospital) attended the deceased from 6/6/72 1972 to 6/18 1972, that (I) (we) last saw the deceased alive on 9/12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                       |
| 23A. SIGNATURE<br>R. Freeman Jr                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 23B. DATE SIGNED<br>9/18/72                                                                                                                                 |                                       |
| 23C. PHYSICIAN'S NAME (Type)<br>N. R. FREEMAN JR                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  | 23D. ADDRESS<br>11W 29th St                                                                                                                                 |                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 24B. DATE<br>9/19/72                                                                                                                                        |                                       |
| 24C. NAME OF CEMETERY or CREMATORY<br>Druid Ridge Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 24D. LOCATION (City, town, or county) (State)<br>Pikesville, Balto. Co., Md.                                                                                |                                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 19 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  | 25B. NAME OF REGISTRAR<br>Sidney [unclear]                                                                                                                  |                                       |
| 25C. FUNERAL DIRECTOR<br>STEWART & MOWEN CO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 25D. ADDRESS<br>108 W. North Av. 1                                                                                                                          |                                       |

UNITED STATES DEPARTMENT OF JUSTICE

ALICE JONES BARNETT

2237 Broadway

July 21, 1903

Portland

London, 1903

112-13-207 Helen W. Jones

ALICE JONES

July 21

W. F. BARNETT

UNITED STATES DEPARTMENT OF JUSTICE  
ALICE JONES BARNETT  
2237 Broadway  
Portland, Oregon  
July 21, 1903

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                                                                                                                                                                                            |                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | REG. NO. <span style="float: right;">72 08963</span>                                                                                                                                                                                                                                                                       |                                           |
| S-530 72 08963                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                       |                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>STUART D.P. SUNDAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 2. DATE AND HOUR OF DEATH<br><b>9/17/72 6:45 pm</b>                                                                                                                                                                                                                                                                        |                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>UNION MEMORIAL HOSPITAL<br/>133 - North Calvert St.<br/>Baltimore, Md 21218</b>                                                                                                                                                                                                                                                                                                                                       |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>7208 BELLONA AVENUE</b> |                                           |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6. RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                | 8. DATE OF BIRTH <b>03-25-10</b>          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>MEDICAL</b>                                                                                                                                                                                                                                                                           | 9. AGE (In years lost birthday) <b>62</b> |
| 11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. AMERICAN</b>                                                                                                                                                                                                                                                                        |                                           |
| 13. FATHER'S NAME <b>HARVEY J. SUNDAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | 14. MOTHER'S MAIDEN NAME <b>MAEBELLE STEWART</b>                                                                                                                                                                                                                                                                           |                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | 16. SOCIAL SECURITY NO. <b>220-44-3697</b>                                                                                                                                                                                                                                                                                 |                                           |
| 17. INFORMANT <b>DOROTHY H. SUNDAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | ADDRESS <b>SAME</b>                                                                                                                                                                                                                                                                                                        |                                           |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>PULMONARY THROMBOEMBOLISM</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>VENA CAVA THROMBOSIS</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>THROMBOSIS RIGHT LEG</b><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>16 days</b>                                                                                                                                                                                                                                            |                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                                                                                                                                                                                                                                            |                                           |
| 19A. DATE OF OPERATION <b>9/16/72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MULT. PULMONARY EMBOLISM</b>                                                                                                                                                                                                                                           |                                           |
| 20A. AUTOPSY? (Yes or No) <b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>PULMONARY EMBOLISM</b>                                                                                                                                                                                                                             |                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                   |                                           |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                  |                                           |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                 |                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/20</b> 19 <b>72</b> to <b>9/17</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9/17</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                             |                      |                                                                                                                                                                                                                                                                                                                            |                                           |
| 23A. SIGNATURE <b>Alfonso Guzman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 23B. DATE SIGNED <b>9/17/72</b>                                                                                                                                                                                                                                                                                            |                                           |
| 23C. PHYSICIAN'S NAME (Type) <b>ALFONSO GUZMAN, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | 23D. ADDRESS <b>UNION MEMORIAL HOSP, BALTO, Md.</b>                                                                                                                                                                                                                                                                        |                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 24B. DATE <b>9-21-72</b>                                                                                                                                                                                                                                                                                                   |                                           |
| 24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      | 24D. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>                                                                                                                                                                                                                                                        |                                           |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 19 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      | 25B. NAME OF REGISTRAR <b>Dr. H.W. Jenkins</b>                                                                                                                                                                                                                                                                             |                                           |
| 25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      | ADDRESS                                                                                                                                                                                                                                                                                                                    |                                           |

15-10-1917

15-10-1917

MASSACHUSETTS

BALTIMORE

1300 NEW YORK AVENUE

03-28-10

M WHITE

PENNSYLVANIA

PHYSICIAN

MARIE LEE STEWART

HARVEY L. GORST

15-10-1917

15-10-1917

VENA CAVA THROMBOSIS

THROMBOSIS OF VENA CAVA

15-10-1917

15-10-1917

15-10-1917

15-10-1917

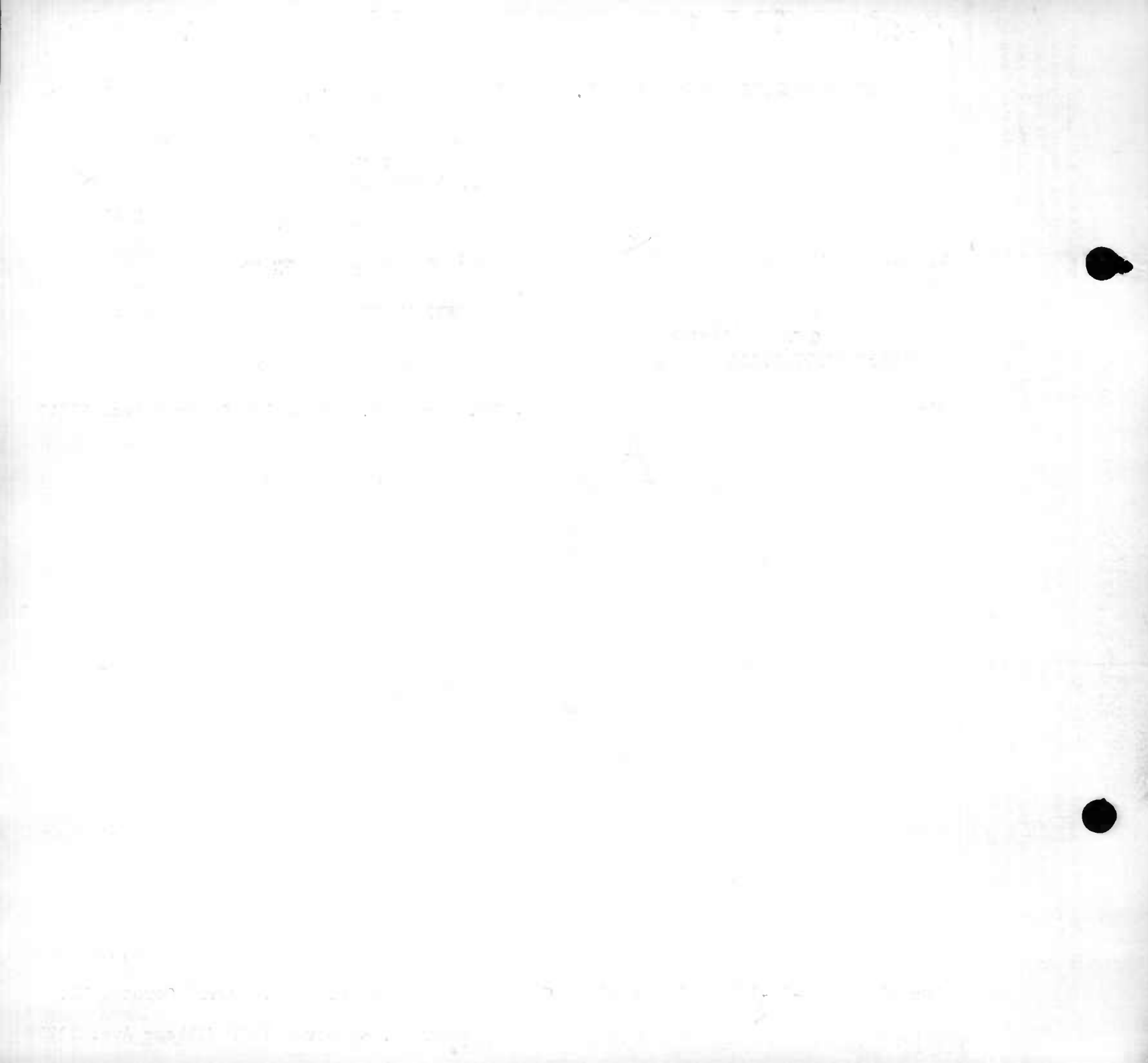
15-10-1917

15-10-1917

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                                                                                                                                                                                                                        |                                      |                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------|
| B-650 72 08964                                                                                                                                                                                                                                                                                                    |                         | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                        |                                      | X REG. NO. 72 08964                                                         |
| BIRTH NO.                                                                                                                                                                                                                                                                                                         |                         | 1. NAME OF DECEASED<br>(Type or Print) <del>XXXXXXXXXXXX</del> <b>ETTA M. BROWN</b>                                                                                                                                                                                                                                                                                    |                                      |                                                                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                            |                         | 2. DATE AND HOUR OF DEATH<br><b>9/17/72 1150 A.M.</b>                                                                                                                                                                                                                                                                                                                  |                                      |                                                                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SOUTH BALTO GEN'L HOSPITAL</b><br><b>43</b>                                                                                                                                                                                                                            |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>LANSDOWNE</b> D. INSIDE CITY LIMITS?<br><del>XXXXXXXXXXXX</del> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER<br><b>203 LAVERNE AVE.</b> <b>21227</b> |                                      |                                                                             |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                           | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                            | 8. DATE OF BIRTH<br><b>5/25/1902</b> | 9. AGE (In years last birthday)<br><b>70</b>                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>                                                                                                                                                                                                   |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                      |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                |
| 13. FATHER'S NAME<br><b>CALAB NUTTER</b><br><del>XXXXXXXXXXXX</del> (Dec.)                                                                                                                                                                                                                                        |                         | 14. MOTHER'S MAIDEN NAME<br><b>EDITH MUIR (Dec.)</b>                                                                                                                                                                                                                                                                                                                   |                                      |                                                                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                             |                         | 16. SOCIAL SECURITY NO.<br><b>212-10-0220-A</b>                                                                                                                                                                                                                                                                                                                        |                                      | 17. INFORMANT<br><b>Mr. Vernon R. Brown, 203 Laverne Ave. 21227</b>         |
| 18. <b>42221-1250-9</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIAC ARREST</b>                                                                |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>CARDIAC ARREST</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                                                                                                                                                     |                                      |                                                                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>ASVD, DIABETES</b>                                                                                                                                                           |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                                           |                                      |                                                                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                            |                         |                                                                                                                                                                                                                                                                                                                                                                        |                                      |                                                                             |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                       |                                      | 20A. AUTOPSY? (Yes or No)<br><b>NOT</b>                                     |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                           |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                               |                                      | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                         |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                              |                                      | 21F. HOW DID INJURY OCCUR?                                                  |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                                                                                                                                                                                                                                        |                                      |                                                                             |
| 23A. SIGNATURE<br><i>Vernon R. Brown</i>                                                                                                                                                                                                                                                                          |                         | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                       |                                      | 23C. PHYSICIAN'S NAME (Type)<br><b>KOUACOVIC</b>                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                         |                         | 24B. DATE<br><b>9-21-1972</b>                                                                                                                                                                                                                                                                                                                                          |                                      | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cemetery</b>           |
| 24D. LOCATION (City, town, or county) (State)<br><b>Wash. Blvd. Howard County, Md.</b>                                                                                                                                                                                                                            |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 19 1972</b>                                                                                                                                                                                                                                                                                                                  |                                      |                                                                             |
| 25B. NAME OF REGISTRAR<br><i>Sidney Hubbard</i>                                                                                                                                                                                                                                                                   |                         | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                                                                             |                                      |                                                                             |

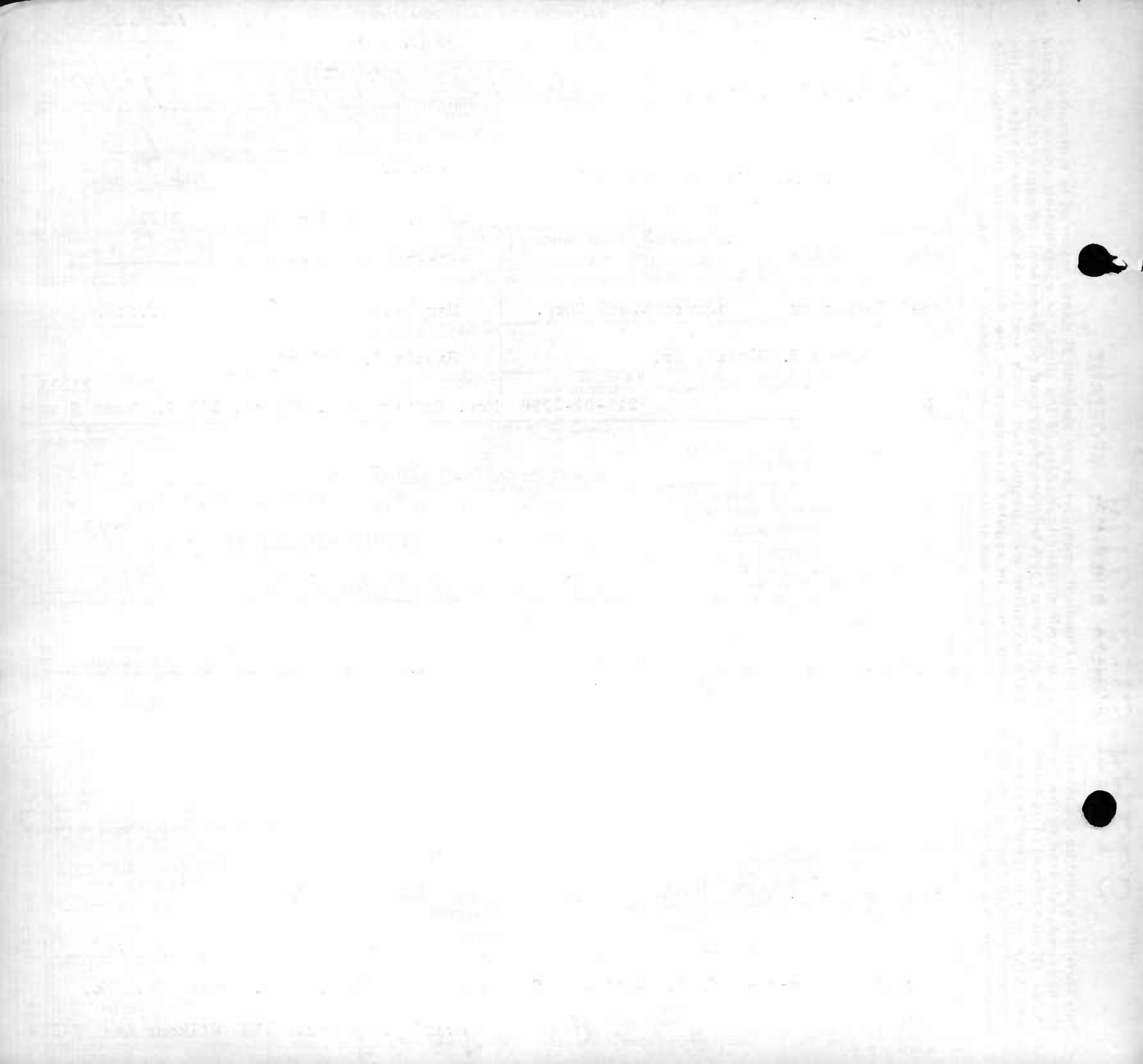




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                               | 72 08965                                                                                                                                                                                                                                                                                                |                                                                       | 72 08965                                                                                                            |                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| BIRTH NO. 4-462                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                               | 72 08965                                                                                                                                                                                                                                                                                                |                                                                       | REG. NO.                                                                                                            |                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Jerome Joseph Ulrich Jr.</b>                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                               | 2. DATE AND HOUR OF DEATH<br><b>9/17/72</b>                                                                                                                                                                                                                                                             |                                                                       | M. <b>1720/P</b>                                                                                                    |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1903</b>                                                                                                                                                              |                                                                       |                                                                                                                     |                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>48 Maryland General Hospital</b>                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                               | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                                                                                                                                                                     |                                                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                       |                                               |
|                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                               | E. STREET AND NUMBER<br><b>215 S. Mount Street</b>                                                                                                                                                                                                                                                      |                                                                       | <b>21223</b>                                                                                                        |                                               |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-28-1917</b>                         | 9. AGE (In years last birthday)<br><b>54</b>                                                                                                                                                                                                                                                            | 10. Under 1 Yr. Months Days                                           | 11. Under 24 Hrs. Hours Min.                                                                                        |                                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Steel Inspector</b>                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Armco Steel Corp.</b> |                                                                                                                                                                                                                                                                                                         | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>          |                                                                                                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Jerome J. Ulrich, Sr.</b>                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                               | 14. MOTHER'S MAIDEN NAME<br><b>Nannie J. Walton</b>                                                                                                                                                                                                                                                     |                                                                       |                                                                                                                     |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>215-01-2798</b>                 |                                                                                                                                                                                                                                                                                                         | 17. INFORMANT<br><b>Mrs. Catherine E. Ulrich, 215 S. Mount Street</b> |                                                                                                                     |                                               |
|                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                               | ADDRESS <b>21223</b>                                                                                                                                                                                                                                                                                    |                                                                       |                                                                                                                     |                                               |
| 18. <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.          |                         |                                                                                                                                                             |                                                               | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Resp. Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>leukemia response to Ca. anemia, dehydration</b><br>(B) <b>hypochromic anemia, mild cerebral, hepatomegaly</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Recurrent bronchogenic Ca; emphysema</b> |                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9/17/72</b>                                                      |                                               |
|                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                               |                                                                                                                                                                                                                                                                                                         |                                                                       | <b>9/72</b>                                                                                                         |                                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>COPD</b>                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                               | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                                                                                                                                                                                                 |                                                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>(If in Baltimore City, give exact location) |                                               |
|                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                               |                                                                                                                                                                                                                                                                                                         |                                                                       |                                                                                                                     |                                               |
| 19A. DATE OF OPERATION<br><b>Jan 72</b>                                                                                                                                                                                                                                                                                                                     |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>adenocarcinoma Ca</b>                                                                                |                                                               | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                                                                                                                                                                                                 |                                                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>(If in Baltimore City, give exact location) |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                           |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                               | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                             |                                                                       |                                                                                                                     |                                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                               | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                              |                                                                       |                                                                                                                     |                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/8</b> 19 <b>72</b> to <b>9/17</b> 19 <b>72</b><br>that (I) (we) last saw the deceased alive on <b>9/17 72P</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                               |                                                                                                                                                                                                                                                                                                         |                                                                       |                                                                                                                     |                                               |
| 23A. SIGNATURE<br><b>William Gilbert Chmura MD</b>                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                               | 23B. DATE SIGNED<br><b>9/17/72</b>                                                                                                                                                                                                                                                                      |                                                                       |                                                                                                                     |                                               |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                               | 23D. ADDRESS<br><b>MARYLAND General Hosp Balt, Md.</b>                                                                                                                                                                                                                                                  |                                                                       |                                                                                                                     |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><b>9-21-1972</b>                                                                                                                               |                                                               | 24C. NAME OF CEMETERY or CREMATORY<br><b>Meadowridge Cemetery</b>                                                                                                                                                                                                                                       |                                                                       | 24D. LOCATION (City, town, or county) (State)<br><b>Wash. Blvd. Howard Co., Md.</b>                                 |                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 19 1972</b>                                                                                                                                                                                                                                                                                                       |                         | 25B. NAME OF REGISTRAR<br><b>Howard H. Hubbard</b>                                                                                                          |                                                               | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                              |                                                                       | ADDRESS                                                                                                             |                                               |

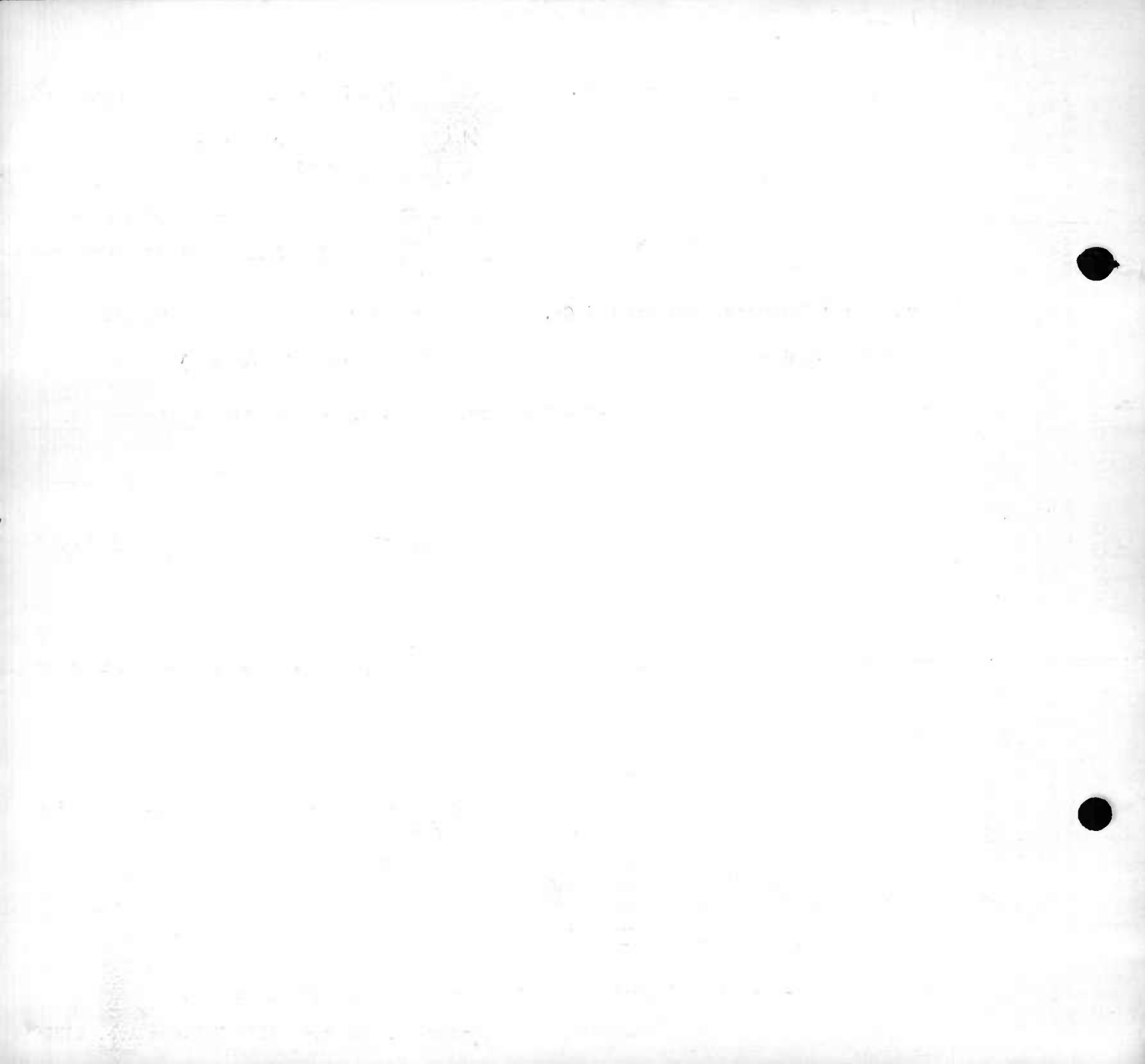




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                              |  | REG. NO. <u>72 08966</u>                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|
| W-526                                                                                                                                                                                                                                                                                                                                                                                  |  | 72 08966                                                                                                                                                                                     |  | CERTIFICATE OF DEATH                                                                   |  |
| BIRTH NO. <u>W-526</u>                                                                                                                                                                                                                                                                                                                                                                 |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Wenker, Leo P., SR.</u>                                                                                                                            |  |                                                                                        |  |
| 2. DATE AND HOUR OF DEATH<br><u>9/17/72</u> <u>10:05 P.M.</u>                                                                                                                                                                                                                                                                                                                          |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Sinai Hospital</u> |  |                                                                                        |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u>                                                                                                                                                                                                                                                 |  | 5. SEX <u>M</u> 6. RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                        |  |
| C. CITY OR TOWN <u>WOODMOOR</u> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                          |  | E. STREET AND NUMBER<br><u>3498 Hillsmere Rd, 21207</u>                                                                                                                                      |  |                                                                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Still Operator</u>                                                                                                                                                                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Standard Oil Co.</u>                                                                                                                                 |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                           |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                          |  | 13. FATHER'S NAME<br><u>John Wenker</u>                                                                                                                                                      |  |                                                                                        |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Friedrica (Unknown)</u>                                                                                                                                                                                                                                                                                                                                 |  | 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                        |  |                                                                                        |  |
| 16. SOCIAL SECURITY NO.<br><u>215-07-2342</u>                                                                                                                                                                                                                                                                                                                                          |  | 17. INFORMANT ADDRESS<br><u>Mrs. Thelma B. Wenker, 3498 Hillsmere Rd. 21207</u>                                                                                                              |  |                                                                                        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>Respiratory arrest</u><br><u>CUA</u><br><u>Myloid Metaplasia</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 min</u><br><u>3 day</u>                                                                                                                |  |                                                                                        |  |
| 19A. DATE OF OPERATION<br><u>9-17-72</u>                                                                                                                                                                                                                                                                                                                                               |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>CUA</u>                                                                                                                               |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                 |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br><u>CUA</u>                                                                                        |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><u>CUA</u> |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br><u>9-17-72</u>                                                                                                                                                                                                                                                                                                            |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                       |  | 21F. HOW DID INJURY OCCUR?<br><u>CUA</u>                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-14-72</u> to <u>9-17-72</u> that (I) (we) last saw the deceased alive on <u>9-17-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                |  |                                                                                                                                                                                              |  |                                                                                        |  |
| 23A. SIGNATURE<br><u>Michael Ference III MD</u>                                                                                                                                                                                                                                                                                                                                        |  | 23B. DATE SIGNED<br><u>9/17/72</u>                                                                                                                                                           |  | 23C. PHYSICIAN'S NAME (Type)<br><u>Michael Ference III MD</u>                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                              |  | 24B. DATE<br><u>9-21-1972</u>                                                                                                                                                                |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Lorraine Park Cemetery</u>                    |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Woodlawn, Maryland</u>                                                                                                                                                                                                                                                                                                             |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 19 1972</u>                                                                                                                                        |  | 25B. NAME OF REGISTRAR<br><u>Sidney Whiston</u>                                        |  |
| 25C. FUNERAL DIRECTOR<br><u>Howard H. Hubbard</u>                                                                                                                                                                                                                                                                                                                                      |  | 25D. ADDRESS<br><u>4107 Wilkens Ave. 21229</u>                                                                                                                                               |  |                                                                                        |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 72-8967                                                                                                                                                     |  | CERTIFICATE OF DEATH                                                               |  | X                                                                                             |  | REG. NO. 72 08967                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 1. NAME OF DECEASED<br>(Type or Print) <u>FAULK, MRS. THOMMIE</u>                                                                                           |  |                                                                                    |  | 2. DATE AND HOUR OF DEATH<br><u>9-18-72</u> <u>1:35</u> P.M.                                  |  |                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>PENNSYLVANIA</u><br>B. COUNTY <u>V35</u>               |  |                                                                                    |  | C. CITY OR TOWN <u>PHILADELPHIA</u>                                                           |  |                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>BON SECOURS HOSPITAL</u>                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |  |                                                                                    |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                      |  |
| 5. SEX<br><u>F</u>                                                                                                                                                                                                                                                                                                                                       |  | 6. RACE<br><u>B</u>                                                                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1-05-35</u>                                                 |  | 9. AGE (In years last birthday) <u>37</u>                                                     |  | 10. Under 1 Yr. Months Days<br>If Under 24 Hrs. Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                              |  |                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  |                                                                                    |  | 11. BIRTHPLACE (State or foreign country)<br><u>VIRGINIA</u>                                  |  |                                                      |  |
| 13. FATHER'S NAME<br><u>JAMES W.S. PAYNE</u>                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><u>LILLIAN WINBUSH</u>                                                                                                          |  |                                                                                    |  | 12. CITIZEN OF WHAT COUNTRY?                                                                  |  |                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 16. SOCIAL SECURITY NO.                                                                                                                                     |  |                                                                                    |  | 17. INFORMANT ADDRESS                                                                         |  |                                                      |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                  |  |                                                                                                           |  | CAUSE OF DEATH                                                                                                                                              |  |                                                                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hepatic Coma</u>                                                                                     |  |                                                                                    |  | <u>days</u>                                                                                   |  |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | (B) <u>Fatty metamorphosis of liver</u><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                  |  |                                                                                    |  | <u>months</u>                                                                                 |  |                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | (C) <u>Chronic Alcoholism</u><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                            |  |                                                                                    |  | <u>years</u>                                                                                  |  |                                                      |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                   |  |                                                                                                           |  | <u>Chronic pancreatitis</u>                                                                                                                                 |  |                                                                                    |  | <u>years</u>                                                                                  |  |                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br><u>yes</u>                                                                                                                     |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>yes</u> |  |                                                                                               |  |                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                 |  |                                                                                    |  |                                                                                               |  |                                                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                             |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                    |  |                                                                                               |  |                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-11-72</u> 19 <u>72</u> to <u>9-18</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                               |  |                                                      |  |
| 23A. SIGNATURE<br><u>Felimon A. Soria</u> MD<br>DEGREE                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | 23B. DATE SIGNED<br><u>9-18-72</u>                                                                                                                          |  |                                                                                    |  | 23C. PHYSICIAN'S NAME (Type)<br><u>FELIMON A. SORIA</u> MD<br>DEGREE                          |  |                                                      |  |
| 23D. ADDRESS<br><u>Bon Secours Hosp. BALT. MD 21223</u>                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                               |  |                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                |  | 24B. DATE<br><u>9/22/72</u>                                                                               |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Eden Cemetery</u>                                                                                                  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Philadelphia Pa</u>            |  |                                                                                               |  |                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 20 1972</u>                                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR<br><u>Adrian W. Wilson</u>                                                         |  | 25C. FUNERAL DIRECTOR<br><u>Adrian W. Wilson</u>                                                                                                            |  | 25D. ADDRESS<br><u>1204 W. North Ave</u>                                           |  |                                                                                               |  |                                                      |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08968

BIRTH NO. 72-09253

|                                                                                                                                                          |  |                                                                                                                            |                                                                                                                                                             |                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Phyllis W. Hill                                                                                                |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month 9 Day 18 Year 72 |                                                                                                                                                             | Hour M.                                                                                                               |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>38 University Hospital |  | 3. DATE PRONOUNCED DEAD<br>Month 9 Day 18 Year 72                                                                          |                                                                                                                                                             | Hour 7:40 a. M.                                                                                                       |
| 6. SEX<br>female                                                                                                                                         |  | 7. RACE<br>Negro                                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                       |
| 9. DATE OF BIRTH<br>6/24/72                                                                                                                              |  | 10. AGE (In years last birthday)<br>3                                                                                      |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                                                      |
| 12. CITIZEN OF<br>USA                                                                                                                                    |  | 13. FATHER'S NAME<br>Emmanuel Hill                                                                                         |                                                                                                                                                             | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 1901 |
| 15. MOTHER'S MAIDEN NAME<br>Ella Smith                                                                                                                   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown)                                                        |                                                                                                                                                             | 17. SOCIAL SECURITY NO.                                                                                               |
| 18. INFORMANT<br>Mr Emmanuel Hill, same                                                                                                                  |  | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>Sudden death in infancy                                              |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                          |

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                          |  |                                                                                                                                                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br>Sudden death in infancy                                                                                                                                                                                 |  | 20. DATE OF OPERATION                                                                                    |  | 21. AUTOPSY? (Yes or No)<br>yes                                                                                                                                              |  |
| 22. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                           |  | 23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                      |  |
| 25. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                   |  | 26. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 27. HOW DID INJURY OCCUR?                                                                                                                                                    |  |
| 28. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 29. ACTUAL SIGNATURE<br>Peter Lipkovic, M.D.                                                             |  | 30. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| 31. DATE REC'D BY HEALTH DEPT.<br>SEP 20 1972                                                                                                                                                                                                                                                                                                                                                                 |  | 32. NAME OF REGISTRAR<br>Audrey H. Heston                                                                |  | 33. FUNERAL DIRECTOR<br>Adolphus Halstead 1206 W North Ave                                                                                                                   |  |

25 0000

UNIVERSITY OF CALIFORNIA

College of Arts and Sciences

Department of Psychology

Psychology

Psychology 101

Psychology 101

Psychology 101

Psychology 101

Psychology 101

Psychology 101

*Handwritten signature*

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08969

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Willy Williams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br>9 18 72 9:20 P. M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1058 Argyle Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 18 72 9:20 P. M.                                                                          |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br>Negro                                                                                                                              |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1703                     |  |
| 9. DATE OF BIRTH<br>12/15/58                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10. AGE (In years last birthday) 13<br>If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.                                                 |  |
| 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. CITIZEN OF<br>WHAT COUNTRY? A                                                                                                             |  |
| 13. FATHER'S NAME<br>Robert Lawson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>School                                          |  |
| 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>Gertrude Williams                                                                                                 |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.                                                                                                                       |  |
| 18. INFORMANT<br>Mrs Gertrude Williams, same                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                                                                                       |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                  |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                              |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Home                                              |  |
| 22D. TIME OF INJURY (APPROX.)<br>9 18 72 P. M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22E. INJURY OCCURRED.<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                         |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>1058 Argyle Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22F. HOW DID INJURY OCCUR?<br>hung self                                                                                                       |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>W P Mulloy</i> M.D.<br>EXAMINER'S NAME (Type) William P. Mulloy, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 9-19-72 |  |                                                                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br>9/23/72                                                                                                                          |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>MT Auburn Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                                                                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 20 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br><i>Adolphus Halstead</i>                                                                                            |  |
| 25C. FUNERAL DIRECTOR<br>Adolphus Halstead                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | ADDRESS<br>1206 W North Ave                                                                                                                   |  |

ST. LOUIS

ST. LOUIS, MO., FEBRUARY 1, 1901

My dear Sir,

I have

been very busy

and have

not had time

to write you

more often

but I am

very sorry

that I cannot

write you

more often

and I am

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that I cannot

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BIRTH NO.

VS 151-REV. 1/1/68

55 10280

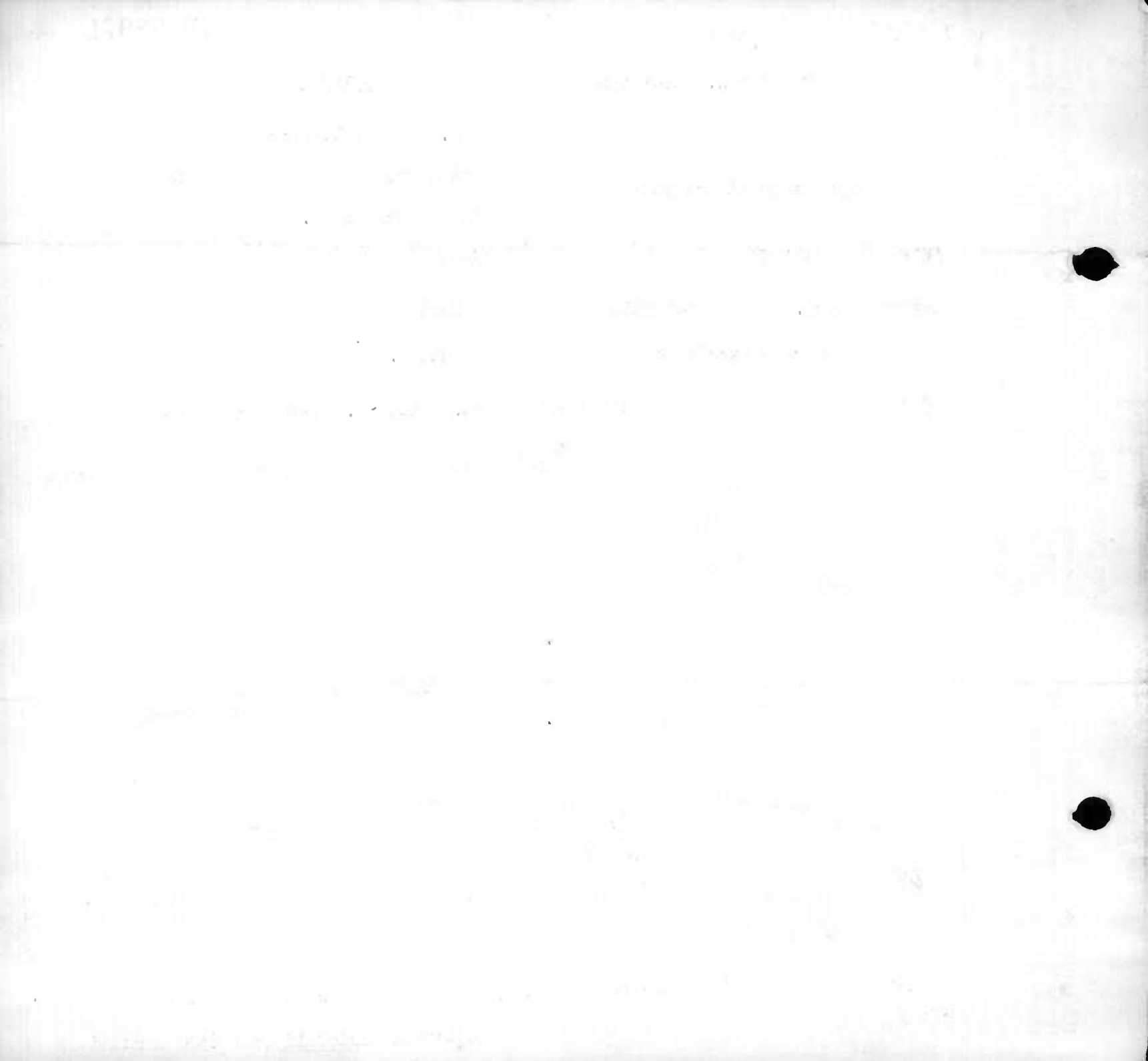
55 10280



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |  | 72 08971                                                                              |                                              | REG. NO. 72 08971                                                                             |                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  | STATE OF MARYLAND-DEATH                                                               |                                              |                                                                                               |                       |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Charles J. Rashleigh</b>                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>9/14/72</b>                                           |                                              |                                                                                               |                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                              |                                                                                               |                       |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 Union Memorial Hospital</b>                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |  | A. STATE<br><b>Md.</b>                                                                |                                              | B. COUNTY<br><b>Baltimore</b>                                                                 |                       |
|                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                   |                                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                       |
|                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  | E. STREET AND NUMBER<br><b>1503 Lochwood Rd.</b>                                      |                                              |                                                                                               |                       |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4/5/1892</b>                                                   | 9. AGE (In years lost birthday)<br><b>80</b> | If Under 1 Yr. Months                                                                         | If Under 24 Hrs. Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Exect.</b>                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Steamship</b>                                 |                                              | 11. BIRTHPLACE (State or foreign country)<br><b>Michigan</b>                                  |                       |
| 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |  |                                                                                       |                                              |                                                                                               |                       |
| 13. FATHER'S NAME<br><b>Joseph Rashleigh</b>                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>Ruth A. Mason</b>                                      |                                              |                                                                                               |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br><b>087035236</b>                                           |                                              | 17. INFORMANT ADDRESS<br><b>Mrs. Lottie W. Rashleigh same</b>                                 |                       |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Myocardial infarction acute</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b> |                         |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b>                         |                                              |                                                                                               |                       |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |  |                                                                                       |                                              |                                                                                               |                       |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                        |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                              |                                                                                               |                       |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                              |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                            |                                              |                                                                                               |                       |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>9/14/72</b> and that (I) <del>was</del> lost saw the deceased alive on <b>4/7/72</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.                                                           |                         |                                                                                                                                                             |  |                                                                                       |                                              |                                                                                               |                       |
| 23A. SIGNATURE<br><b>W.B. Daniels, Jr. M.D.</b>                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  | 23B. DATE SIGNED<br><b>9/15/72</b>                                                    |                                              |                                                                                               |                       |
| 23C. PHYSICIAN'S NAME (Type)<br><b>W. B. Daniels, Jr.</b>                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  | 23D. ADDRESS<br><b>11 E. Chase St. Baltimore Md 21202</b>                             |                                              |                                                                                               |                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                 |                         | 24B. DATE<br><b>9/18/72</b>                                                                                                                                 |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Dulaney Valley Men Gds</b>                   |                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Cockeysville Balto Md.</b>                |                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                                                                                     |                         | 25B. NAME OF REGISTRAR<br><b>Admiral [Signature]</b>                                                                                                        |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Mitchell Wiedefeld Home 6500 York Rd</b>          |                                              |                                                                                               |                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                |               |                                                                                                                                                          |                                                                                             | REG. NO. 72 08972                                                                          |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. K-656                                                                                                                                                                                                 |               |                                                                                                                                                          |                                                                                             | 72 08972                                                                                   |                                                           |
| 1. NAME OF DECEASED (Type or Print) LAWRENCE KERNER                                                                                                                                                             |               |                                                                                                                                                          |                                                                                             | 2. DATE AND HOUR OF DEATH 9/16/72 5 <sup>10</sup> P.M.                                     |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                          |               |                                                                                                                                                          |                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)      |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND                                                                         |               |                                                                                                                                                          |                                                                                             | A. STATE MARYLAND                                                                          |                                                           |
|                                                                                                                                                                                                                 |               |                                                                                                                                                          |                                                                                             | C. CITY OR TOWN BALTIMORE                                                                  |                                                           |
|                                                                                                                                                                                                                 |               |                                                                                                                                                          |                                                                                             | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
|                                                                                                                                                                                                                 |               |                                                                                                                                                          |                                                                                             | E. STREET AND NUMBER 3706, NORIONA ROAD                                                    |                                                           |
| 5. SEX Male                                                                                                                                                                                                     | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-28-1891                                                                  | 9. AGE (In years last birthday) 81 yrs                                                     | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED                                                                                                             |               |                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country) BALTIMORE                                         |                                                                                            | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                       |
| 13. FATHER'S NAME ?                                                                                                                                                                                             |               |                                                                                                                                                          | 14. MOTHER'S MAIDEN NAME ?                                                                  |                                                                                            |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service. No                                                                                                      |               |                                                                                                                                                          | 16. SOCIAL SECURITY NO. 216-07-8561                                                         |                                                                                            | 17. INFORMANT WALTER L. KERNER 432 S. PARRISH ST.         |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                              |               |                                                                                                                                                          | CAUSE OF DEATH                                                                              |                                                                                            |                                                           |
| (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                          |               |                                                                                                                                                          | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary Deceleration 25 minutes |                                                                                            |                                                           |
| ANTECEDENT CAUSES                                                                                                                                                                                               |               |                                                                                                                                                          | (B) ? Acute cardiac failure. DUE TO, OR AS A CONSEQUENCE OF: 5 days                         |                                                                                            |                                                           |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.                                                                                                           |               |                                                                                                                                                          | (C) Fracture (R) femur neck. 5 days                                                         |                                                                                            |                                                           |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Bronchial asthma. over 40 yrs                                               |               |                                                                                                                                                          |                                                                                             |                                                                                            |                                                           |
| 19A. DATE OF OPERATION 9-13-72                                                                                                                                                                                  |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture neck (R) femur                                                                                 |                                                                                             | 20A. AUTOPSY? (Yes or No) Yes                                                              |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Notify medical examiner                                                                                                    |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) nursing home                                                    |                                                                                             | 21C. WHERE DID INJURY OCCUR? Greenwood Acres Nursing Home 15-09                            |                                                           |
| 21D. TIME OF INJURY (APPROX) 9 10 72 10:00 P.M.                                                                                                                                                                 |               | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input checked="" type="checkbox"/>                                        |                                                                                             | 21F. HOW DID INJURY OCCUR? Fell off bed                                                    |                                                           |
| 22. I certify that (1) (this hospital) attended the deceased from 9-11-1972 to 9-16-1972                                                                                                                        |               |                                                                                                                                                          |                                                                                             |                                                                                            |                                                           |
| that (1) (we) last saw the deceased alive on 9-16-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (f) (We) (did) (did not) view the body after death. |               |                                                                                                                                                          |                                                                                             |                                                                                            |                                                           |
| 23A. SIGNATURE M.D. [Signature]                                                                                                                                                                                 |               |                                                                                                                                                          |                                                                                             | 23B. DATE SIGNED 9-18-72                                                                   |                                                           |
| 23C. PHYSICIAN'S NAME (Type) DR. M. A. ANWAR M.D.                                                                                                                                                               |               |                                                                                                                                                          |                                                                                             | 23D. ADDRESS Lutheran Hospital of Maryland                                                 |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 9/20/72                                                                                                                                                                |               | 24B. DATE 9/20/72                                                                                                                                        |                                                                                             | 24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL Cemetery                                  |                                                           |
|                                                                                                                                                                                                                 |               |                                                                                                                                                          |                                                                                             | 24D. LOCATION (City, town, or county) (State) Edmonson Ave                                 |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1972                                                                                                                                                                     |               | 25B. NAME OF REGISTRAR [Signature]                                                                                                                       |                                                                                             | 25C. FUNERAL DIRECTOR [Signature] ADDRESS 1600 HOLLINS ST.                                 |                                                           |

9/13/68 - Alm.

432 S. Parrish St,

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |                                               | 72 08973                                                                                                                                                                                                                                                                                                   |                                                                   | 72 08973                                                             |                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                               | REG. NO.                                                                                                                                                                                                                                                                                                   |                                                                   | STATE OF MARYLAND-DHMH                                               |                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BALDWIN CRILDA E.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                             |                                               | 2. DATE AND HOUR OF DEATH<br><b>Sept 16, 1972 8:35 PM M.</b>                                                                                                                                                                                                                                               |                                                                   |                                                                      |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>North Charles General Hosp.</b>                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                             |                                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>BALTO. MD</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>68 Fenwick South Essex</b> |                                                                   |                                                                      |                                               |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/18/17</b>            |                                                                                                                                                                                                                                                                                                            | 9. AGE (In years last birthday)<br><b>55</b>                      | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.                 |                                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY             |                                                                                                                                                                                                                                                                                                            | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b> |                                                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Gelan Kessel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Calhoun</b>    |                                                                                                                                                                                                                                                                                                            |                                                                   |                                                                      |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>216-22-6590</b> |                                                                                                                                                                                                                                                                                                            | 17. INFORMANT<br><b>Chart</b>                                     |                                                                      |                                               |
| 18. I <b>1621 I</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Metastatic Carcinoma of the lung</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last<br><b>Pulmonary Emphysema</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b><br><b>Years</b> |                     |                                                                                                                                                             |                                               |                                                                                                                                                                                                                                                                                                            |                                                                   |                                                                      |                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                             |                                               |                                                                                                                                                                                                                                                                                                            |                                                                   |                                                                      |                                               |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                               | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                  |                                                                   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                   |                                                                   |                                                                      |                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                               | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                 |                                                                   |                                                                      |                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> 19 <b>72</b> to <b>Sept 16</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                          |                     |                                                                                                                                                             |                                               |                                                                                                                                                                                                                                                                                                            |                                                                   |                                                                      |                                               |
| 23A. SIGNATURE<br><b>Said H. A. Shahabi</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                               | 23B. DATE SIGNED<br><b>9/17/72</b>                                                                                                                                                                                                                                                                         |                                                                   | 23C. PHYSICIAN'S NAME (Type)<br><b>SAID HOSSEIN A. SHAHABI</b>       |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                               | 24B. DATE<br><b>9/20/72</b>                                                                                                                                                                                                                                                                                |                                                                   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Crest Lawn Cemetery</b>     |                                               |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |                                               | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                      |                                                                   |                                                                      |                                               |
| 25B. NAME OF REGISTRAR<br><b>Robert C. Altenburg</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |                                               | 25C. FUNERAL DIRECTOR<br><b>Robert C. Altenburg Funeral Home, Inc.</b>                                                                                                                                                                                                                                     |                                                                   |                                                                      |                                               |
| 25D. ADDRESS<br><b>6009 Harford Rd. Balto., Md. 21214</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |                                               |                                                                                                                                                                                                                                                                                                            |                                                                   |                                                                      |                                               |

0000-00-000



| STATE OF MARYLAND-DEPT. OF HEALTH<br>BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                           |  | 72 08974                                                                                                                                                                                           |  |                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                           |  | REG. NO. 72 08974                                                                                                                                                                                  |  |                                                                                               |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                           |  |                                                                                                                                                                                                    |  |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) Nelson L. Freney                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                           |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 9 14 72 1:35 A.M.                                                          |  |                                                                                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Loch Raven V. A. Hospital                                                                                                                                                                                                                                                                                                                                                     |  |                                           |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 14 72 1:35 A.M.                                                                                                                                |  |                                                                                               |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY Wicomico                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                           |  |                                                                                                                                                                                                    |  |                                                                                               |  |
| 6. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. RACE<br>White                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                        |  | C. CITY OR TOWN<br>Salisbury                                                                  |  |
| 9. DATE OF BIRTH<br>12/10/1899                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10. AGE (In years last birthday) 72       |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                              |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 12. CITIZEN OF<br>USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 13. FATHER'S NAME<br>Joshua L. Freney     |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>Mary Anne Fooks                                                   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes WW I                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 17. SOCIAL SECURITY NO.<br>214-32-5695    |  | 18. INFORMANT<br>Mr. Robert M. Russell, Huntington, W. Va.                                                                                                                                         |  | ADDRESS                                                                                       |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>Fracture right hip |  |                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                       |  |                                                                                               |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                           |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                   |  |                                                                                               |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                           |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                           |  |                                                                                               |  |
| 22D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                           |  | 22E. INJURY OCCURRED                                                                                                                                                                               |  |                                                                                               |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                           |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                           |  |                                                                                               |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                         |  |                                           |  | 21. AUTOPSY? (Yes or No)<br>Yes                                                                                                                                                                    |  |                                                                                               |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>William P. Mulloy, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                           |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br>9-15-72 |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24B. DATE<br>9/18/72                      |  | 24C. NAME OF CEMETERY or CREMATORY<br>Wicomico Memorial Park                                                                                                                                       |  | 24D. LOCATION (City, town, or county) (State)<br>Salisbury, Wicomico, Maryland                |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 20 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 25B. NAME OF REGISTRAR<br>Sidney Johnston |  | 25C. FUNERAL DIRECTOR ADDRESS<br>Holloway Funeral Home, Salisbury, Maryland                                                                                                                        |  |                                                                                               |  |

10-12-1972 - Completion of cause of death on a pending medical examiner death certificate  
Wm. P. Mulloy, M.D. HRS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                        | REG. NO. <b>72 08975</b>                                                               |                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. <b>R-500</b>                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                        | 72 08975                                                                               |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>RAINEY, JENEVIAH</b>                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                                                                                                                        | 2. DATE AND HOUR OF DEATH<br><b>9/13/72 10:10 A.M.</b>                                 |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>MARYLAND GENERAL HOSPITAL</b>                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> |                                                                                        |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>48</b>                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                                                        |                                                           |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | E. STREET AND NUMBER<br><b>602 P</b>                                                                                                   |                                                                                        |                                                           |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>BLACK</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/18/17</b>                                                                                                     | 9. AGE (in years last birthday)<br><b>55</b>                                           | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>                                                                                                                                                                                                   |                         |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>ONANCOCK VA.</b>                                                                       |                                                                                        |                                                           |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                                            |                                                                                        |                                                           |
| 13. FATHER'S NAME<br><b>JOHN KELLAM</b>                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>MARY ETTA MASON</b>                                                                                     |                                                                                        |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                             |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>214-20-7387</b>                                                                                          |                                                                                        |                                                           |
| 17. INFORMANT<br><b>TERLENA DRUMMOND</b>                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | ADDRESS<br><b>717 CAREY ST BALTO MD.</b>                                                                                               |                                                                                        |                                                           |
| 18. <b>433,71</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CEREBRAL THROMBOSIS</b>                                                                 |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 DAYS</b>                                                                         |                                                                                        |                                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>HYPOTENSION</b>                                                                                                                                                              |                         |                                                                                                                                                             | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>10 DAYS</b>                                                                                  |                                                                                        |                                                           |
| (C) <b>AGUTE UGI BLEEDING</b>                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | <b>10 DAYS</b>                                                                                                                         |                                                                                        |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                        |                                                                                        |                                                           |
| 19A. DATE OF OPERATION<br><b>9-17-72</b>                                                                                                                                                                                                                                                                          |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                        | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                    |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Yes</b> |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                         |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                        |                                                                                                                                        | 21F. HOW DID INJURY OCCUR?                                                             |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                                        |                                                                                        |                                                           |
| 23A. SIGNATURE<br><b>D. N. Naeem</b>                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                                                        | 23B. DATE SIGNED<br><b>9-14-72</b>                                                     |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>AMATUN - NOOR NAEEM</b>                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                        | 23D. ADDRESS<br><b>827 Linden Avenue Maryland General Hospital</b>                     |                                                           |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                        |                         | 24B. DATE<br><b>9-17-72</b>                                                                                                                                 |                                                                                                                                        | 24C. NAME OF CEMETERY or CREMATORY<br><b>Sunter Com.</b>                               |                                                           |
| 24D. LOCATION<br><b>Onancock, Va.</b>                                                                                                                                                                                                                                                                             |                         | 24E. LOCATION (City, town, or county) (State)                                                                                                               |                                                                                                                                        | 24F. LOCATION (City, town, or county) (State)                                          |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                             |                         | 25B. NAME OF REGISTRAR<br><b>Smallwood - Princess Anne, Md.</b>                                                                                             |                                                                                                                                        | 25C. FUNERAL DIRECTOR<br><b>Smallwood - Princess Anne, Md.</b>                         |                                                           |

7/10/92 Adm.

333 Gwynn Ave. 19

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>C-560</span> <span>72 18976</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>                                                                                                                                                                                                           |                                                                                                                                                                       | REG. NO. <span style="float: right;">72 18976</span>                                                                                                                                                                                                                                                                                   |
| BIRTH NO. _____<br>1. NAME OF DECEASED<br>(Type or Print) <b>CONROY, MARY VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                       | 2. DATE AND HOUR OF DEATH<br><b>SEPTEMBER 18 1972 10:20A</b> M.                                                                                                                                                                                                                                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST. AGNES HOSPITAL</b><br><b>CERTIFICATE AMENDED</b>                                                                                                                                                                                             |                                                                                                                                                                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2553</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2052 WHISTLER AVENUE 21230</b> |
| 5. SEX <b>FEMALE</b><br>6. RACE <b>CAUCASIAN</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                | 8. DATE OF BIRTH <b>09 03 14</b><br>9. AGE (In years last birthday) <b>58</b><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                            | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MACHINE OPERATOR</b><br>10B. KIND OF BUSINESS OR INDUSTRY <b>PAPER CO</b>                                                                                                                                                            |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                       | 13. FATHER'S NAME <b>XXXXXXXXXXXXXXXXXXXX William Dixon</b><br>14. MOTHER'S MAIDEN NAME <b>Myrtle Rollins Schapiro</b><br><b>DOROTHY ( ) SCHAPIRO</b>                                                                                                                                                                                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or at unknown) (If yes, give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                       | 16. SOCIAL SECURITY NO. <b>218 78 7944</b><br>17. INFORMANT <b>RECORDS</b><br><b>ST. AGNES HOSPITAL CATON &amp; WILKENS</b>                                                                                                                                                                                                            |
| 18. <b>43619</b> I.S.S. #218-07-7944<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                       |                                                                                                                                                                       | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Coma, Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                                                                |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                         |                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                        |
| 19A. DATE OF OPERATION <b>0</b><br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____              | 20A. AUTOPSY? (Yes or No) _____<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____                                                                                                                                                                                                                      |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____<br>22. I certify that (X) (this hospital) attended the deceased from <b>SEPTEMBER 15 19 72</b> to <b>SEPTEMBER 18 19 72</b> , that (XX) (we) last saw the deceased alive on <b>SEPTEMBER 18 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR? _____                            |                                                                                                                                                                                                                                                                                                                                        |
| 23A. SIGNATURE <b>S. N. Moussavian, M.D.</b><br>23C. PHYSICIAN'S NAME (Type) <b>SEYED MOUSSAVIAN MD</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                       | 23B. DATE SIGNED <b>09 18 72</b><br>23D. ADDRESS <b>CATON &amp; WILKENS AVENUE 21229</b>                                                                                                                                                                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b><br>24B. DATE <b>9/21/72</b><br>24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b><br>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>                                                                                                                                                                                                     | 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1972</b><br>25B. NAME OF REGISTRAR <b>Mc Gally Funeral Home</b><br>25C. FUNERAL DIRECTOR <b>130 E. Fort Ave.</b><br>ADDRESS |                                                                                                                                                                                                                                                                                                                                        |

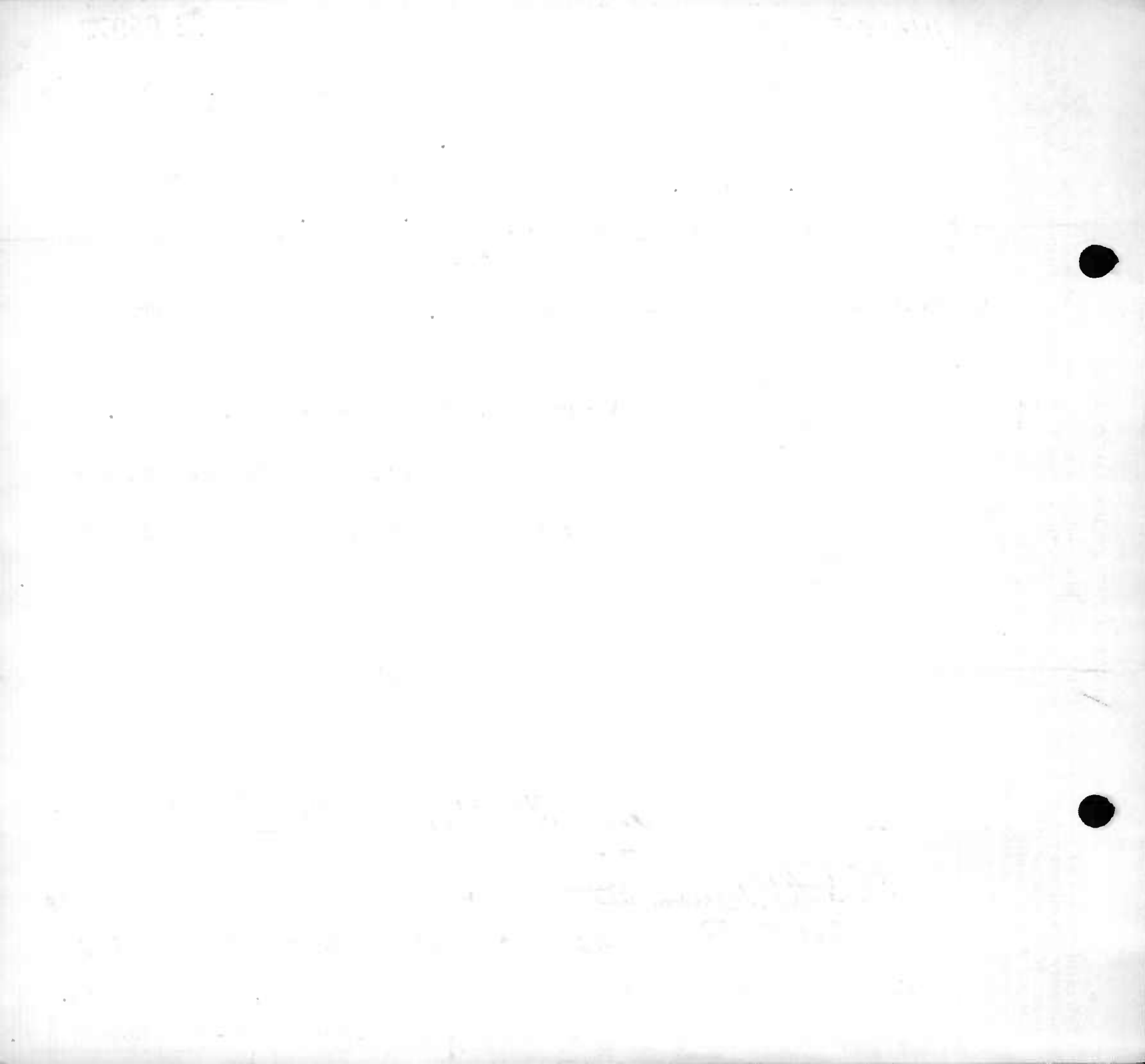
11-20-1972 - Letter from St. Agnes Hospital, 900 Caton Ave., Balto., Md. for correction,  
signed by Paul Coakley, Director, Admissions and Communications. HRS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                         | REG. NO. <b>72 08977</b>                                       |                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|
| BIRTH NO. <b>M-235</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 72 08977                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                         | STATE OF MARYLAND-DHMH                                         |                                                            |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Neal McDonald</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>September 18, 1972 12<sup>30</sup> P.M.</b>                                                                                                                                                                                                                                             |                                                                |                                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1000 W. 41st St.</b>                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>1307</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1000 W. 41st St.</b> |                                                                |                                                            |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/3/04</b>                                                                                                                                                                                                                                                                                       | 9. AGE (In years last birthday)<br><b>68</b>                   | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Painter</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self-employed</b>                                                                                                   |                                                                                                                                                                                                                                                                                                                         | 11. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>        |                                                            |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 13. FATHER'S NAME<br><b>Unknown</b>                                                                                                                                                                                                                                                                                     |                                                                |                                                            |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service<br><b>Yes WWII</b>                                                                                                                                                                                               |                                                                |                                                            |
| 16. SOCIAL SECURITY NO.<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 17. INFORMANT ADDRESS<br><b>Leona McDonald-1000W. 41st St.</b>                                                                                              |                                                                                                                                                                                                                                                                                                                         |                                                                |                                                            |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>412.31 Congestive Heart Failure</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 7 days</b><br><b>(B) Anterior Sclerotic Vas Heart Dis. 2 yrs.</b><br><b>(C)</b> |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                         |                                                                |                                                            |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                         |                                                                |                                                            |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                         | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                         |                                                            |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                     |                                                                                                                                                                                                                                                                                                                         |                                                                |                                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                         | 21C. WHERE DID INJURY OCCUR?                                   |                                                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                         | 21F. HOW DID INJURY OCCUR?                                     |                                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <b>July 21 1969</b> to <b>June 12 1972</b> that (I) (we) lost saw the deceased alive on <b>June 12 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                         |                                                                |                                                            |
| 23A. SIGNATURE<br><b>Carl F. Benson md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                         | 23B. DATE SIGNED<br><b>Sept. 19, 1972</b>                      |                                                            |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Carl F. Benson md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                         | 23D. ADDRESS<br><b>5111 York Rd Balto Md 21212</b>             |                                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 24B. DATE<br><b>9/20/72</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                         | 24C. NAME OF CEMETERY or CREMATORY<br><b>Woodlawn Cemetery</b> |                                                            |
| 24D. LOCATION<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                       |                                                                                                                                                                                                                                                                                                                         |                                                                |                                                            |
| 25B. NAME OF REGISTRAR<br><b>Dorothy W. H. H.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Donovan Funeral Home-3818 Roland Ave.</b>                                                                               |                                                                                                                                                                                                                                                                                                                         |                                                                |                                                            |

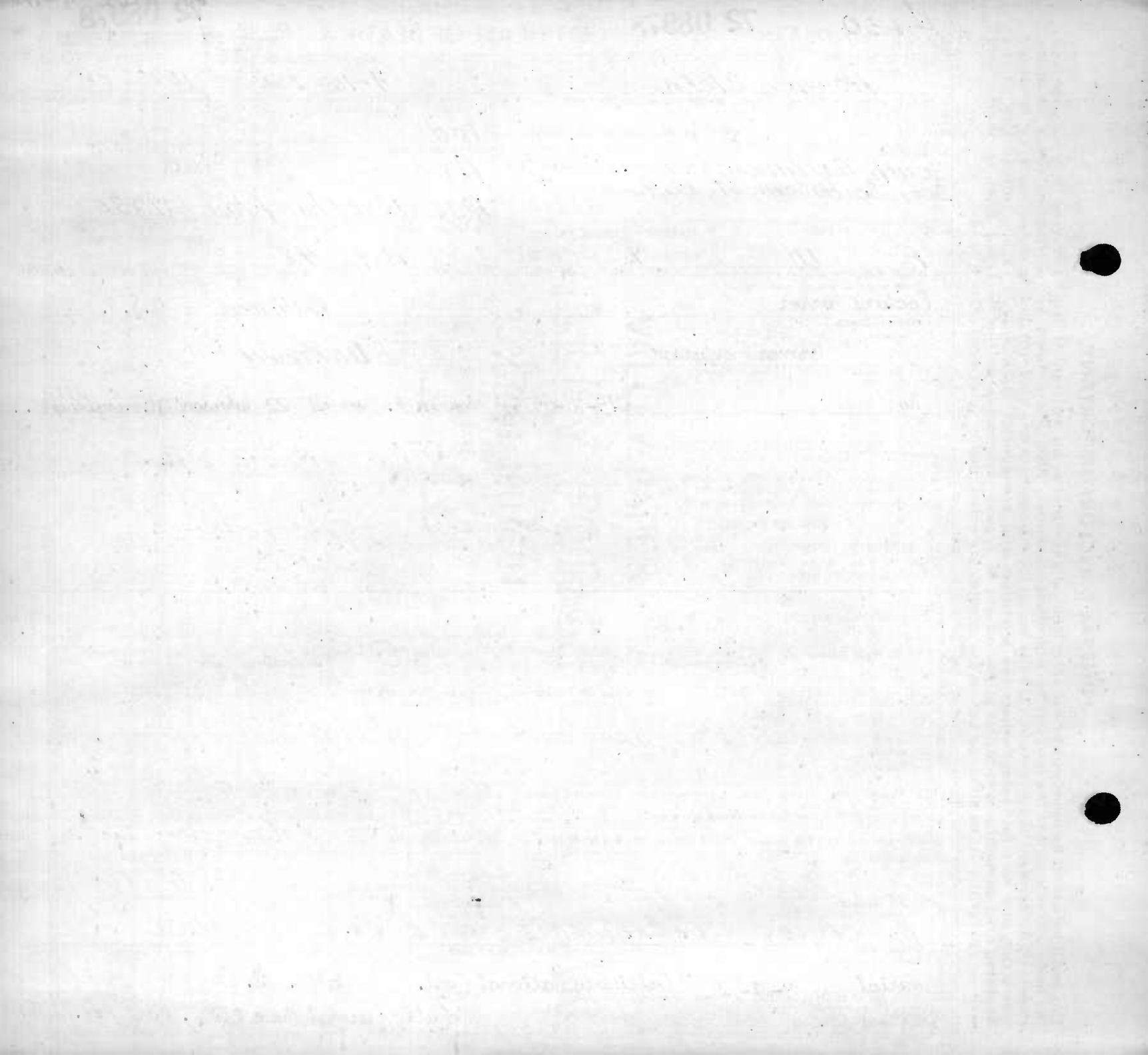




**FUNERAL DIRECTOR: IMPORTANT**

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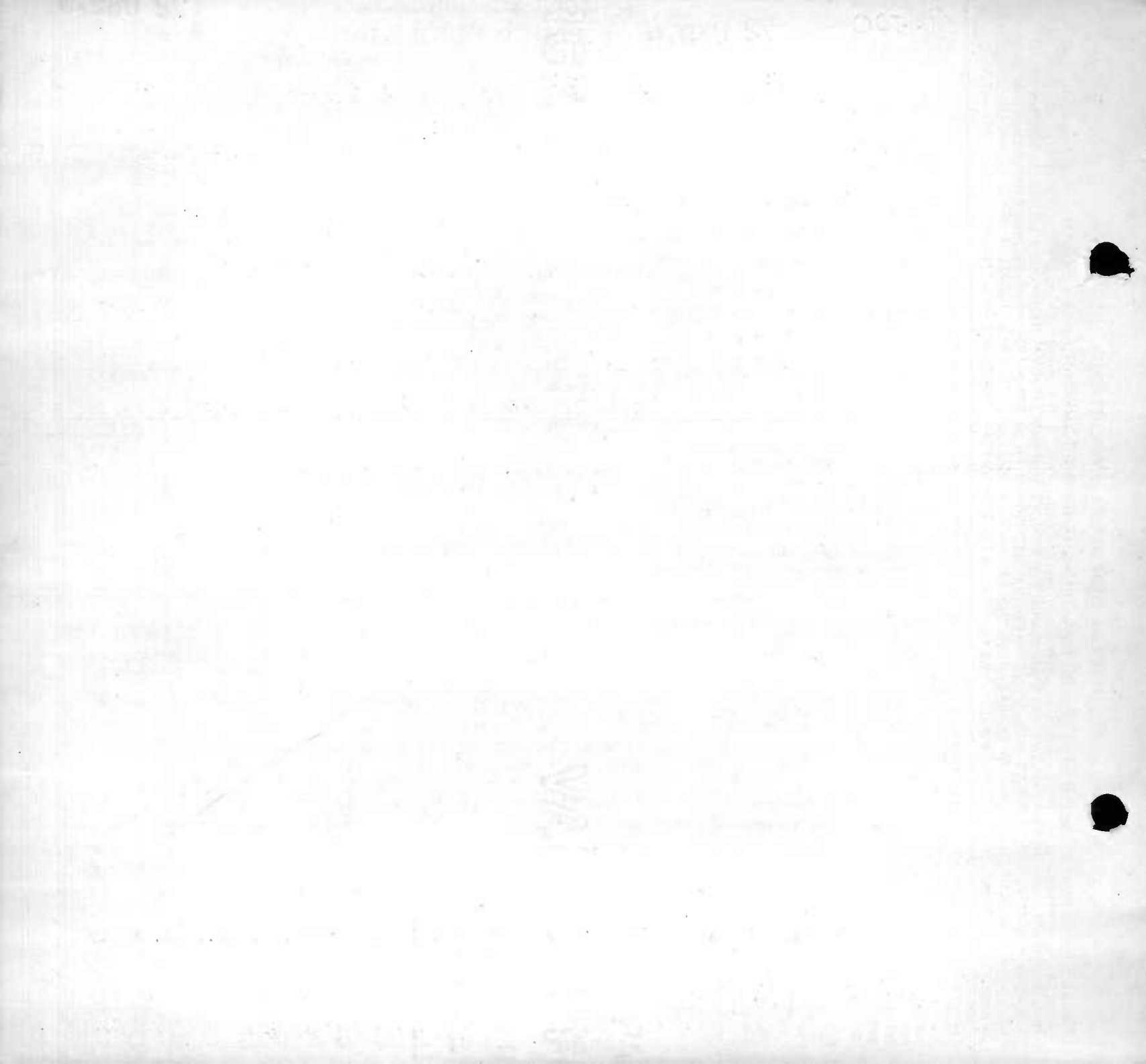
| H-630 72 08978                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                    |  | REG. NO. 72 08978                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | STATE OF MARYLAND-DEATH                                                                                                                             |  |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Howard, Cletia</u>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 2. DATE AND HOUR OF DEATH<br><u>9-16-72</u> <u>10:05 PM</u> M.                                                                                      |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>md.</u> 8. COUNTY <u>2404</u>                  |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>South Baltimore General Hospital</u><br><u>3001 So. Hanover St. Baltimore Md.</u><br><u>21230</u>                                                                                                                                                                                                                                                                                    |  |  |  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                 |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                            |  |  |  | 8. DATE OF BIRTH<br><u>1924</u> 9. AGE (In years last birthday) <u>48</u>                                                                           |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Factory Worker</u>                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore</u>                                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 13. FATHER'S NAME<br><u>Grover Ferguson</u>                                                                                                         |  |                                                                                               |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Un Known</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                               |  |                                                                                               |  |
| 16. SOCIAL SECURITY NO.<br><u>215-16-6975</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 17. INFORMANT<br><u>Warren R. Howard</u> ADDRESS <u>22 Johnson Rd. Pasadena Md. 21122</u>                                                           |  |                                                                                               |  |
| 18. <u>430.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Subarachnoid Hem.</u><br>(B) <u>Essential Hypertension</u><br>(C) _____ |  |                                                                                               |  |
| 19A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                    |  | 20A. AUTOPSY (Yes or No) <u>0</u>                                                             |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                            |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><u>yes</u>     |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                           |  | 21F. HOW DID INJURY OCCUR?                                                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> 19 <u>72</u> to <u>9-16</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>9/16/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>10:05 PM</u>                                                                                                                                        |  |  |  |                                                                                                                                                     |  |                                                                                               |  |
| 23A. SIGNATURE<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | 23B. DATE SIGNED<br><u>9-16-72</u>                                                                                                                  |  | 23C. PHYSICIAN'S NAME (Type)<br><u>DR. CARLOS N. PATAKINGHUS</u>                              |  |
| 23D. ADDRESS<br><u>SOUTH BALT. GEN. HOSP.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                           |  |                                                                                               |  |
| 24B. DATE<br><u>9-21-72</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Baltimore National Cemt.</u>                                                                               |  | 24D. LOCATION (City, town, or county) (State)<br><u>Balto. Md.</u>                            |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 20 1972</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | 25B. NAME OF REGISTRAR<br><u>[Signature]</u>                                                                                                        |  | 25C. FUNERAL DIRECTOR<br><u>McCully Funeral Home</u> ADDRESS <u>130 E. Fort Ave. 21230</u>    |  |



# FUNERAL DIRECTOR: IMPORTANT

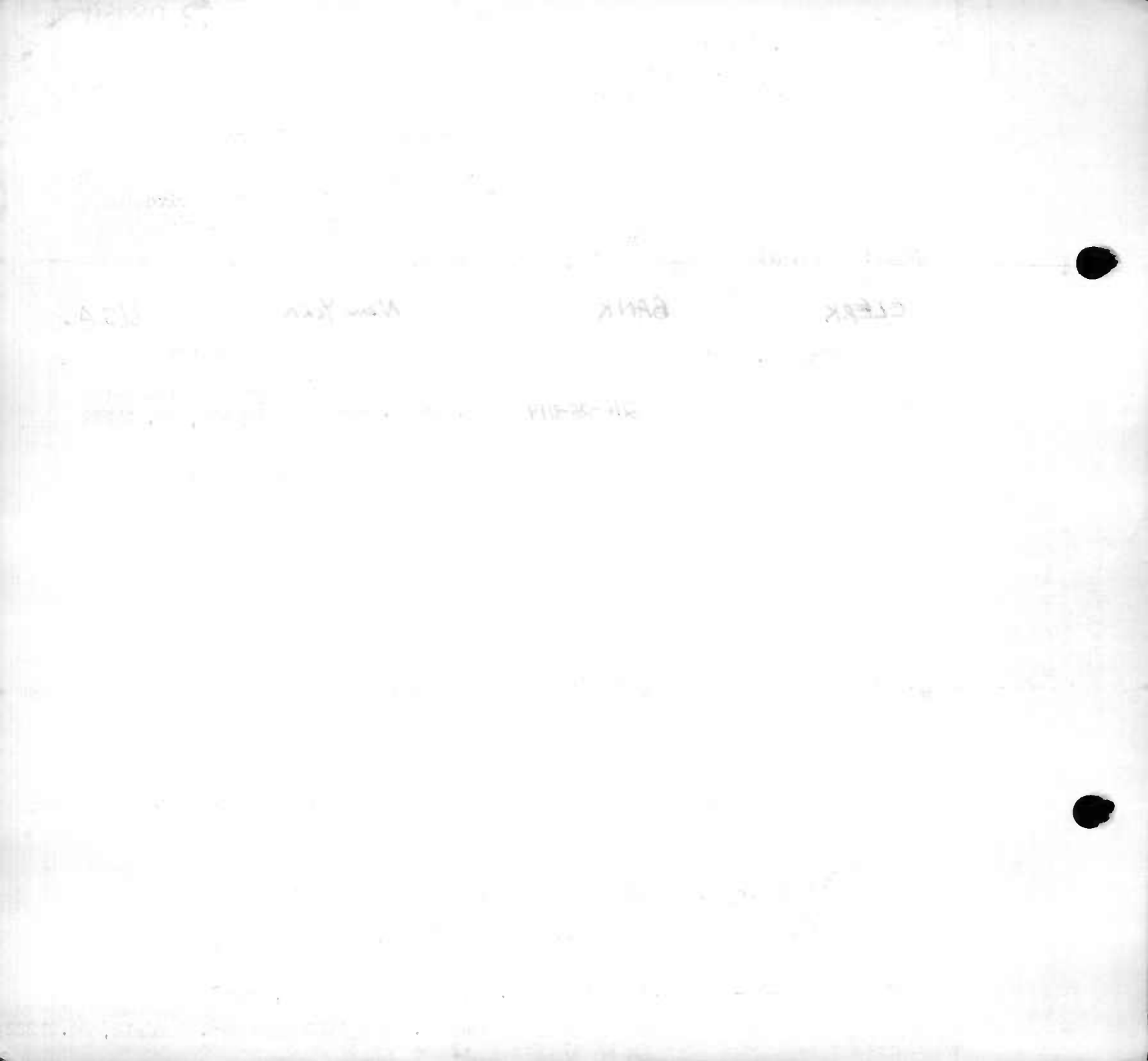
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                               |  | 72 08979                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                               |  | REG. NO. <u>72 08979</u>                                                 |
| BIRTH NO. <u>C-500</u>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 1. NAME OF DECEASED<br>(Type or Print) <u>ROBERT E. CHANEY</u>                                                                                                                                |  |                                                                          |
| 2. DATE AND HOUR OF DEATH<br><u>9/16/72</u> <u>10:45 A.M.</u>                                                                                                                                                                                                                                                                                                                                                                        |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                        |  |                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>00</u>                                                                                                                                                                                                                                                                                                                                                                                    |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>5211 ST. GEORGES AVE.</u>                                                                                          |  |                                                                          |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>MD.</u><br>B. COUNTY <u>BALTO.</u>                                                                                                                                                                                                                                                                                              |  | C. CITY OR TOWN <u>BALTO.</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                   |  |                                                                          |
| E. STREET AND NUMBER<br><u>5211 ST. GEORGES AVE.</u>                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX <u>M</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                          |
| 8. DATE OF BIRTH <u>8/26/06</u> 9. AGE (In years last birthday) <u>66</u>                                                                                                                                                                                                                                                                                                                                                            |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Exterminator</u>                                                                             |  |                                                                          |
| 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u>                                                                                                                                                                                                                                                                                                                                                                              |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                 |  |                                                                          |
| 13. FATHER'S NAME<br><u>THOS. CHANEY</u>                                                                                                                                                                                                                                                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><u>MABEL JACKSON</u>                                                                                                                                              |  |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                                                                                                |  | 16. SOCIAL SECURITY NO.<br><u>214-20-1871</u>                                                                                                                                                 |  | 17. INFORMANT<br><u>SINETA CHANEY-5211 ST. GEO. AVE.</u>                 |
| 18. <u>410.9</u> I                                                                                                                                                                                                                                                                                                                                                                                                                   |  | CAUSE OF DEATH                                                                                                                                                                                |  |                                                                          |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                        |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>MYOCARDIAL INFARCT</u>                                                                                                           |  |                                                                          |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                                       |  | (B) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                           |  |                                                                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                               |  | <u>PEPTIC ULCER DISEASE</u>                                                                                                                                                                   |  |                                                                          |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                              |  | 20A. AUTOPSY? (Yes or No)                                                |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                              |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                      |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                            |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                     |  | 21F. HOW DID INJURY OCCUR?                                               |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>7 JUNE</u> 19 <u>72</u> to <u>16 SEPT</u> 19 <u>72</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>17 AUGUST</u> 19 <u>72</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>Was</del> ) ( <del>did</del> ) (did not) view the body after death. |  |                                                                                                                                                                                               |  |                                                                          |
| 23A. SIGNATURE<br><u>Charles O'Donovan, III</u>                                                                                                                                                                                                                                                                                                                                                                                      |  | 23B. DATE SIGNED<br><u>18 SEPT 1972</u>                                                                                                                                                       |  | 23C. PHYSICIAN'S NAME (Type)<br><u>Charles O'Donovan, III</u>            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br><u>9/21/72</u>                                                                                                                                                                   |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Pleasant Rest</u>               |
| 24D. LOCATION (City, town, or county) (State)<br><u>TOXSON, BALTO. CO. MD.</u>                                                                                                                                                                                                                                                                                                                                                       |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 20 1972</u>                                                                                                                                         |  |                                                                          |
| 25B. NAME OF REGISTRAR<br><u>Sineta Chaney</u>                                                                                                                                                                                                                                                                                                                                                                                       |  | 25C. FUNERAL DIRECTOR<br><u>Chapman Funeral Home - 1701 N. Calleg St. Balto. MD.</u>                                                                                                          |  |                                                                          |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                                                  |  |  |                                                                          |  |  |                                                                      |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------|--|--|----------------------------------------------------------------------|--|--|
| E-256                                                                                                                                                                                                                                                                                                       |  |  | 72 08980                                                                                                                         |  |  | BIRTH NO.                                                                |  |  | 72 08980                                                             |  |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                   |  |  | 1. NAME OF DECEASED                                                                                                              |  |  | 2. DATE AND HOUR OF DEATH                                                |  |  | REG. NO.                                                             |  |  |
| (Type or Print)                                                                                                                                                                                                                                                                                             |  |  | Ruth L. Egner                                                                                                                    |  |  | 9/14/72                                                                  |  |  | STATE OF MARYLAND-DHMH                                               |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                      |  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)                                            |  |  | 5. SEX                                                                   |  |  | 6. RACE                                                              |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                        |  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                             |  |  | A. STATE                                                                 |  |  | B. COUNTY                                                            |  |  |
| MARYLAND GEN. HOSP.                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                  |  |  | Maryland                                                                 |  |  | Baltimore                                                            |  |  |
| 48                                                                                                                                                                                                                                                                                                          |  |  | C. CITY OR TOWN                                                                                                                  |  |  | D. INSIDE CITY LIMITS?                                                   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
|                                                                                                                                                                                                                                                                                                             |  |  | Dundalk                                                                                                                          |  |  |                                                                          |  |  |                                                                      |  |  |
|                                                                                                                                                                                                                                                                                                             |  |  | E. STREET AND NUMBER                                                                                                             |  |  | 117 Bayside Drive                                                        |  |  |                                                                      |  |  |
|                                                                                                                                                                                                                                                                                                             |  |  | 117 Bayside Dr.                                                                                                                  |  |  |                                                                          |  |  |                                                                      |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                                                                                                                       |  |  | 8. DATE OF BIRTH                                                                                                                 |  |  | 9. AGE (In years last birthday)                                          |  |  | 10. AGE (In years last birthday)                                     |  |  |
| FEMALE                                                                                                                                                                                                                                                                                                      |  |  | 6/3/15                                                                                                                           |  |  | 57                                                                       |  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.            |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                 |  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                |  |  | 11. BIRTHPLACE (State or foreign country)                                |  |  | 12. CITIZEN OF WHAT COUNTRY?                                         |  |  |
| CLERK                                                                                                                                                                                                                                                                                                       |  |  | BANK                                                                                                                             |  |  | New York                                                                 |  |  | USA.                                                                 |  |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                           |  |  | 14. MOTHER'S MAIDEN NAME                                                                                                         |  |  | 17. INFORMANT                                                            |  |  | ADDRESS                                                              |  |  |
| Claud J. West                                                                                                                                                                                                                                                                                               |  |  | Hazel Duffield                                                                                                                   |  |  | Husband:                                                                 |  |  | 117 Bayside Drive                                                    |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                    |  |  | 16. SOCIAL SECURITY NO.                                                                                                          |  |  | Mr. Roy M. Egner                                                         |  |  | Dundalk, Md. 21222                                                   |  |  |
| No                                                                                                                                                                                                                                                                                                          |  |  | 216-28-8119                                                                                                                      |  |  |                                                                          |  |  |                                                                      |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                          |  |  | CAUSE OF DEATH                                                                                                                   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |  |                                                                      |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                              |  |  | Acute Liver Atrophy                                                      |  |  |                                                                      |  |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                           |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |  |                                                                          |  |  |                                                                      |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.                                                                                                                                                                                                   |  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                              |  |  |                                                                          |  |  |                                                                      |  |  |
| II                                                                                                                                                                                                                                                                                                          |  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  |  |                                                                          |  |  |                                                                      |  |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                      |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  |  | 20A. AUTOPSY? (Yes or No)                                                |  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 8/25                                                                                                                                                                                                                                                                                                        |  |  | LAPAROTOMY                                                                                                                       |  |  | Yes                                                                      |  |  |                                                                      |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                     |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                         |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |                                                                      |  |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                               |  |  | 21E. INJURY OCCURRED                                                                                                             |  |  | 21F. HOW DID INJURY OCCUR?                                               |  |  |                                                                      |  |  |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                 |  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                |  |  |                                                                          |  |  |                                                                      |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8/19 1972 to 9/14 1972 that (I) (we) last saw the deceased alive on Sept 14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  | 23A. SIGNATURE                                                                                                                   |  |  | 23B. DATE SIGNED                                                         |  |  |                                                                      |  |  |
| A. Brucker MD.                                                                                                                                                                                                                                                                                              |  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  |  |                                                                          |  |  |                                                                      |  |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                |  |  | 23D. ADDRESS                                                                                                                     |  |  |                                                                          |  |  |                                                                      |  |  |
| A. BRUCKER M.D.                                                                                                                                                                                                                                                                                             |  |  | Md. Gen. Hosp.                                                                                                                   |  |  |                                                                          |  |  |                                                                      |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                    |  |  | 24B. DATE                                                                                                                        |  |  | 24C. NAME OF CEMETERY or CREMATORY                                       |  |  | 24D. LOCATION (City, town, or county) (State)                        |  |  |
| Burial                                                                                                                                                                                                                                                                                                      |  |  | 9-18-72                                                                                                                          |  |  | Meadowridge Mem. Park                                                    |  |  | Dorsey, Maryland                                                     |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                             |  |  | 25B. NAME OF REGISTRAR                                                                                                           |  |  | 25C. FUNERAL DIRECTOR                                                    |  |  | ADDRESS                                                              |  |  |
| SEP 20 1972                                                                                                                                                                                                                                                                                                 |  |  | Sidney W. [unclear]                                                                                                              |  |  | John J. Duda                                                             |  |  | 7922 Wise Ave. Dundalk, Md. 21222                                    |  |  |
| VS 19-REV. 1/1/68                                                                                                                                                                                                                                                                                           |  |  |                                                                                                                                  |  |  |                                                                          |  |  |                                                                      |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                              |  |                                                                                       |  |                                                                                                                                                                                                                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                             |  | 72 08981                                                                              |  | 72 08981                                                                                                                                                                                                                                                                                           |  |
| BIRTH NO.                                                                                                                                    |  | 72 08981                                                                              |  | REG. NO. 72 08981                                                                                                                                                                                                                                                                                  |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                       |  | 2. DATE AND HOUR OF DEATH                                                             |  | STATE OF MARYLAND-DEMH                                                                                                                                                                                                                                                                             |  |
| Kenneth Lambert                                                                                                                              |  | 9/18/72 7:35 A.M.                                                                     |  | 5600                                                                                                                                                                                                                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                       |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  | 5. CITY OR TOWN                                                                                                                                                                                                                                                                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                 |  | A. STATE<br>Md                                                                        |  | B. COUNTY                                                                                                                                                                                                                                                                                          |  |
| SINAI Hospital Bldg                                                                                                                          |  | New Windsor Rd                                                                        |  | INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                         |  |
| 6. SEX                                                                                                                                       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>            |  | 8. DATE OF BIRTH                                                                                                                                                                                                                                                                                   |  |
| M.                                                                                                                                           |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 9/29/15                                                                                                                                                                                                                                                                                            |  |
| 6. RACE                                                                                                                                      |  | 9. AGE (In years last birthday)                                                       |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                         |  |
| W                                                                                                                                            |  | 56                                                                                    |  | Night Watchman                                                                                                                                                                                                                                                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                     |  | 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                          |  |
| CLOTHING FACTORY                                                                                                                             |  | MARYLAND                                                                              |  | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                       |  |
| 13. FATHER'S NAME                                                                                                                            |  | 14. MOTHER'S MAIDEN NAME                                                              |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                           |  |
| ARTHUR S LAMBERT                                                                                                                             |  | NELLIE CASHMAN                                                                        |  | YES W W II                                                                                                                                                                                                                                                                                         |  |
| 16. SOCIAL SECURITY NO.                                                                                                                      |  | 17. INFORMANT                                                                         |  | ADDRESS                                                                                                                                                                                                                                                                                            |  |
| 218-01-1921                                                                                                                                  |  | Chas-MRS RICHARD SELBY                                                                |  | NEW WINDSOR                                                                                                                                                                                                                                                                                        |  |
| 18. CAUSE OF DEATH                                                                                                                           |  | 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                       |  |
| 189.0 I                                                                                                                                      |  | Septicemia, Sepsis                                                                    |  | Hours                                                                                                                                                                                                                                                                                              |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  | Hypertension Metastatic to heart                                                                                                                                                                                                                                                                   |  |
| ANTECEDENT CAUSES                                                                                                                            |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |  | Months                                                                                                                                                                                                                                                                                             |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |  | (C) _____                                                                             |  | _____                                                                                                                                                                                                                                                                                              |  |
| II                                                                                                                                           |  |                                                                                       |  |                                                                                                                                                                                                                                                                                                    |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).             |  |                                                                                       |  |                                                                                                                                                                                                                                                                                                    |  |
| 19A. DATE OF OPERATION                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                          |  |
| 0                                                                                                                                            |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                           |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                     |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                       |  | 21E. INJURY OCCURRED                                                                                                                                                                                                                                                                               |  |
| 21F. HOW DID INJURY OCCUR?                                                                                                                   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>     |  | 22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that (in my) (our) opinion death occurred on the date _____ and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |
| 23A. SIGNATURE                                                                                                                               |  | 23B. DATE SIGNED                                                                      |  | 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                       |  |
| Dr. Cherry, Jr.                                                                                                                              |  | 9/18/72                                                                               |  | Dr. Cherry, Jr.                                                                                                                                                                                                                                                                                    |  |
| 23D. ADDRESS                                                                                                                                 |  | 23E. NAME OF CEMETERY OR CREMATORY                                                    |  | 23F. LOCATION (City, town, or county) (State)                                                                                                                                                                                                                                                      |  |
| SINAI Hospital                                                                                                                               |  | WINTERS                                                                               |  | NEW WINDSOR RURAL MD                                                                                                                                                                                                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                     |  | 24B. DATE                                                                             |  | 24C. NAME OF HEALTH DEPT.                                                                                                                                                                                                                                                                          |  |
| BURIAL                                                                                                                                       |  | 9/21/72                                                                               |  | SEP 20 1972                                                                                                                                                                                                                                                                                        |  |
| 24D. NAME OF REGISTRAR                                                                                                                       |  | 24E. FUNERAL DIRECTOR                                                                 |  | 24F. ADDRESS                                                                                                                                                                                                                                                                                       |  |
| Sidney Wharton                                                                                                                               |  | D. D. Hartzler & Sons                                                                 |  | New Windsor                                                                                                                                                                                                                                                                                        |  |

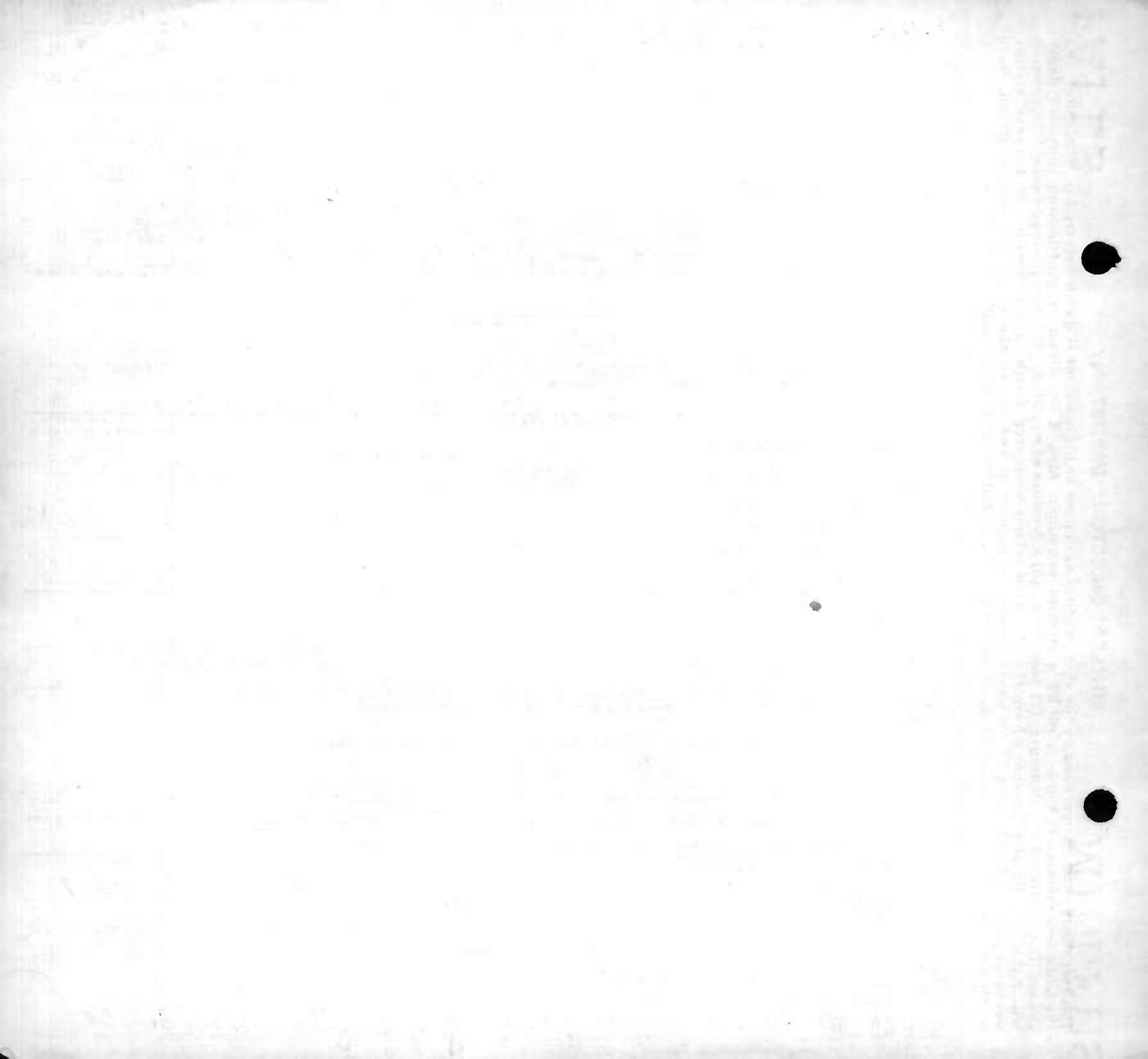




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                      |                   |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                              |                                                                          |                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                     |                   | 72 08982                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                              | REG. NO. 72 08982                                                        |                                                           |
| BIRTH NO. J-162                                                                                                                                                                                                                                                                                                                      |                   | 72 08982                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                              | STATE OF MARYLAND-DHMH                                                   |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY M. JEFFRIES</b>                                                                                                                                                                                                                                                                       |                   |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>09-16-72 17:37 A.M.</b>                                                                                                                                                                                                                                                                      |                                                                          |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Union Memorial Hospital</b>                                                                                                                            |                   |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1305</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>3214 Keswick Road</b> |                                                                          |                                                           |
| 5. SEX <b>F.</b>                                                                                                                                                                                                                                                                                                                     | 6. RACE <b>W.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>05-09-87</b>                                                                                                                                                                                                                                                                                          | 9. AGE (In years last birthday) <b>85</b>                                | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                      |                   |                                                                                                                                                             | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                 |                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>American</b>           |
| 13. FATHER'S NAME<br><b>Henry Wessel</b>                                                                                                                                                                                                                                                                                             |                   |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                                                                                                                                                                                                                                                                                   |                                                                          |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                |                   |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>BC-65-040349 IND.</b>                                                                                                                                                                                                                                                                          |                                                                          | 17. INFORMANT<br><b>RAYMOND JEFFRIES</b>                  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiorespiratory arrest</b>                                                                                                |                   |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 h.</b>                                                                                                                                                                                                                                                                 |                                                                          |                                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>3.6 Years</b>                                                                                                                                                                                   |                   |                                                                                                                                                             | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Acute Myocardial Infarction</b>                                                                                                                                                                                                                                                    |                                                                          |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                     |                   |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                              |                                                                          |                                                           |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                   |                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                              | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                  |                                                           |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                              |                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                                                                     |                                                                                                                                                                                                                                                                                                                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                            |                   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                              | 21F. HOW DID INJURY OCCUR?                                               |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>09-15-72</b> 19__ to <b>09-16-72</b> 19__ that (I) (we) last saw the deceased alive on <b>09-16-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                   |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                              |                                                                          |                                                           |
| 23A. SIGNATURE<br><b>Dante Hanyari, M.D.</b>                                                                                                                                                                                                                                                                                         |                   |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                              | 23B. DATE SIGNED<br><b>09-16-72</b>                                      |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DANTE HANYARI, M.D.</b>                                                                                                                                                                                                                                                                           |                   |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                              | 23D. ADDRESS<br><b>The Union Memorial Hospital</b>                       |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                            |                   | 24B. DATE<br><b>9-19-72</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                              | 24C. NAME OF CEMETERY or CREMATORY<br><b>SESSOP</b>                      |                                                           |
| 24D. LOCATION<br><b>PHOENIX BALTO Co. Md</b>                                                                                                                                                                                                                                                                                         |                   | 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                       |                                                                                                                                                                                                                                                                                                                              | 25B. NAME OF REGISTRAR<br><b>Lindsey Whitton</b>                         |                                                           |
| 25C. FUNERAL DIRECTOR<br><b>Frank W. SEITZ</b>                                                                                                                                                                                                                                                                                       |                   | 25D. ADDRESS<br><b>814 W 36th St</b>                                                                                                                        |                                                                                                                                                                                                                                                                                                                              |                                                                          |                                                           |



72 08983

STATE OF MARYLAND - BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08983

BIRTH NO.

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |                                                                                                                                                                                       |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Charles Robinson</b>                                                                                                                                                                                                                                                                                                                                                |  |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>9</b> Day <b>17</b> Year <b>72</b> Hour <b>10:20</b> M. <b>P.</b>           |  |  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>5807 Glenkirk Avenue</b>                                                                                                                                                                                                                                                                                 |  |  |  | 3. DATE PRONOUNCED DEAD<br>Month <b>9</b> Day <b>17</b> Year <b>72</b> Hour <b>10:20</b> M. <b>P.</b>                                                                                 |  |  |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2748</b>                                                                                                                                                                                                                                                                            |  |  |  | 6. SEX <b>male</b> 7. RACE <b>White</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 9. DATE OF BIRTH<br><b>Aug. 21, 1950</b>                                                                                                                                                                                                                                                                                                                                                                      |  |  |  | 10. AGE (In years last birthday) <b>22</b>                                                                                                                                            |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Washington D.C.</b>                                                                                                                                                                                                                                                                                                                                           |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                            |  |  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>                                                                                                                                                                                                                                                                                                 |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Janet Zapf</b>                                                                                                                                         |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                          |  |  |  | 17. SOCIAL SECURITY NO.<br><b>219-50-3843</b>                                                                                                                                         |  |  |  |
| 18. INFORMANT<br><b>Mr. Melvin O. Robinson</b>                                                                                                                                                                                                                                                                                                                                                                |  |  |  | ADDRESS<br><b>Same</b>                                                                                                                                                                |  |  |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>E 955 X</b>                                                                                                                                                                                           |  |  |  | CAUSE OF DEATH<br><b>Gunshot wound of head</b>                                                                                                                                        |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  |  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  |  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                   |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                   |  |  |  |
| 20A. DATE OF OPERATION<br><b>9/21/72</b>                                                                                                                                                                                                                                                                                                                                                                      |  |  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                      |  |  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                            |  |  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>HOME</b>                                                                               |  |  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>5807 Glenkirk Ave. - 2nd floor</b>                                                                                                                                                                                                                                                                                             |  |  |  | 22F. HOW DID INJURY OCCUR?<br><b>Self inflicted.</b>                                                                                                                                  |  |  |  |
| 22D. TIME OF INJURY (APPROX.)<br>Month <b>9</b> Day <b>17</b> Year <b>72</b> Hour <b>10:12</b> P.M.                                                                                                                                                                                                                                                                                                           |  |  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                  |  |  |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                                       |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>                                                                                                                                                                                                                                                                                                                                        |  |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                                        |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                                   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  |  |  | 24B. DATE<br><b>9/21/72</b>                                                                                                                                                           |  |  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Moreland Memorial Park</b>                                                                                                                                                                                                                                                                                                                                           |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Maryland</b>                                                                                                            |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 25B. NAME OF REGISTRAR<br><b>Sidney...</b>                                                                                                                                            |  |  |  |
| 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>                                                                                                                                                                                                                                                                                                                                   |  |  |  | ADDRESS                                                                                                                                                                               |  |  |  |

N 85971720004979

*Handwritten signature*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | REG. NO. <b>72 08984</b>                                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| B-423 72 08984                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | STATE OF MARYLAND-DHM                                                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | 1. NAME OF DECEASED                                                                        |  |
| (Type or Print)                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | 2. DATE AND HOUR OF DEATH                                                                  |  |
| <b>JOSEPHINE BELLISTRI</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                        |  | Sept. 18, 1972 13.15 a. M.                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                   |  |                                                                                                        |  | A. STATE: <b>Maryland</b>                                                                  |  |
| <b>00 4303 Arabia Avenue</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |  | B. COUNTY: <b>2702</b>                                                                     |  |
| 5. SEX: <b>female</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  | C. CITY OR TOWN: <b>Baltimore</b>                                                          |  |
| 6. RACE: <b>caucasian</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                    |  |                                                                                                        |  | E. STREET AND NUMBER: <b>4303 Arabia Ave.</b>                                              |  |
| 8. DATE OF BIRTH: <b>Feb. 10, 1893</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 9. AGE (In years last birthday): <b>79</b>                                                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housewife</b>                                                                                                                                                                                                                               |  |                                                                                                        |  | 11. BIRTHPLACE (State or foreign country): <b>Italy</b>                                    |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA Italy</b>                                              |  |
| 13. FATHER'S NAME: <b>Sebastiano Maggiore</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 14. MOTHER'S MAIDEN NAME: <b>Rosaria Bellistri</b>                                         |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): <b>no</b>                                                                                                                                                                                                                         |  |                                                                                                        |  | 16. SOCIAL SECURITY NO.                                                                    |  |
| 17. INFORMANT: <b>Carmelo Bellistri, 4303 Arabia Ave.</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  | ADDRESS                                                                                    |  |
| 18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                            |  |                                                                                                        |  | CAUSE OF DEATH: <b>Arteriosclerotic Cardio Vascular Disease</b>                            |  |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                  |  |                                                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>5 per</b>                                 |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                        |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                   |  |                                                                                                        |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                        |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | (D) DUE TO, OR AS A CONSEQUENCE OF:                                                        |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                            |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20A. AUTOPSY? (Yes or No)                                                                  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                     |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                 |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>May 8 1967</b> to <b>Sept 18 1972</b> , that (I) (we) last saw the deceased alive on <b>September 17 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                            |  |
| 23A. SIGNATURE: <b>Philip D. Flynn</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  | 23B. DATE SIGNED: <b>9/18/72</b>                                                           |  |
| 23C. PHYSICIAN'S NAME (Type): <b>Dr. Philip D. Flynn</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  | 23D. ADDRESS: <b>11 E. Chase St, Balto, Md.</b>                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify): <b>Burial</b>                                                                                                                                                                                                                                                                                     |  | 24B. DATE: <b>9-21-72</b>                                                                              |  | 24C. NAME of CEMETERY or CREMATORY: <b>Most Holy Redeemer</b>                              |  |
| 24D. LOCATION: <b>Balto., Md.</b>                                                                                                                                                                                                                                                                                                           |  | 24E. DATE REC'D BY HEALTH DEPT.                                                                        |  | 24F. NAME OF REGISTRAR: <b>Leonard J. Ruck, Inc.-Balto, Md.</b>                            |  |
| 25A. DATE REC'D BY HEALTH DEPT.: <b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR: <b>Leonard J. Ruck, Inc.-Balto, Md.</b>                                        |  | 25C. FUNERAL DIRECTOR ADDRESS: <b>Leonard J. Ruck, Inc.-Balto, Md.</b>                     |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                     |                                    | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                 | REG. NO.                                                                        |                                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------------------------------|
| S-351                                                                                                                                                                                                                                                                                                                                                                         |                                    | 72 08985                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                 | 72 08985                                                                        |                                                                        |
| <div style="display: flex; justify-content: space-between;"> <div> <p>1. NAME OF DECEASED<br/>(Type or Print)</p> <p><b>STEMP, FRANK</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH</p> <p><b>SEPTEMBER 16 1972 6:35A.M.</b></p> </div> </div>                                                                                                                             |                                    |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |                                                                        |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p><b>UNIVERSITY OF MARYLAND HOSPITAL</b></p>                                                                                                                                                                                                                                                                   |                                    |                                                                                                                                                                        | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>MARYLAND</b> B. COUNTY <b>FRED.</b></p> <p>C. CITY OR TOWN <b>FREDERICK</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <b>VALLEY VIEW RT. NO. 4</b></p> |                                                                                 |                                                                        |
| <p>5. SEX</p> <p><b>MALE</b></p>                                                                                                                                                                                                                                                                                                                                              | <p>6. RACE</p> <p><b>WHITE</b></p> | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p> | <p>8. DATE OF BIRTH</p> <p><b>4-2-11</b></p>                                                                                                                                                                                                                                                                                                    | <p>9. AGE (in years last birthday)</p> <p><b>61</b></p>                         | <p>10. Under 1 Yr. Months: Days: Hours: Min.</p>                       |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Electronic Tech</b></p>                                                                                                                                                                                                                                              |                                    | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p><b>Self employed</b></p>                                                                                                   |                                                                                                                                                                                                                                                                                                                                                 | <p>11. BIRTHPLACE (State or foreign country)</p> <p><b>Penna.</b></p>           |                                                                        |
| <p>13. FATHER'S NAME</p> <p><b>STANLEY STEMP</b></p>                                                                                                                                                                                                                                                                                                                          |                                    |                                                                                                                                                                        | <p>14. MOTHER'S MAIDEN NAME</p> <p><b>SOPHIA BRESKI</b></p>                                                                                                                                                                                                                                                                                     |                                                                                 |                                                                        |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service</p> <p>Yes <b>W.W. 2</b></p>                                                                                                                                                                                                                                        |                                    | <p>16. SOCIAL SECURITY NO.</p> <p><b>232-01-1350</b></p>                                                                                                               |                                                                                                                                                                                                                                                                                                                                                 | <p>17. INFORMANT ADDRESS</p> <p><b>Charles Stemp-Paw-Paw, W. Va. 25434</b></p>  |                                                                        |
| <p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> |                                    |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                 | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>8 DAYS</b></p>        |                                                                        |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>                                                                                                                                                                                                                             |                                    |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                 | <p><b>8 DAYS</b></p>                                                            |                                                                        |
| <p>19A. DATE OF OPERATION</p> <p><b>MARCH 1972</b></p>                                                                                                                                                                                                                                                                                                                        |                                    | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>                                                                                                                |                                                                                                                                                                                                                                                                                                                                                 | <p>20A. AUTOPSY? (Yes or No)</p>                                                |                                                                        |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>                                                                                                                                                                                                                                                                                  |                                    | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                        |                                                                                                                                                                                                                                                                                                                                                 | <p>21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)</p> |                                                                        |
| <p>21D. TIME OF INJURY (APPROX.)</p>                                                                                                                                                                                                                                                                                                                                          |                                    | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                   |                                                                                                                                                                                                                                                                                                                                                 | <p>21F. HOW DID INJURY OCCUR?</p>                                               |                                                                        |
| <p>22. I certify that (I) (his hospital) attended the deceased from <b>SEPT. 8 1972</b> to <b>SEPT. 16 1972</b> that (I) (we) last saw the deceased alive on <b>SEPT. 16 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>                                |                                    |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |                                                                        |
| <p>23A. SIGNATURE</p> <p><b>A. Gatzdula M.D.</b></p>                                                                                                                                                                                                                                                                                                                          |                                    |                                                                                                                                                                        | <p>23B. DATE SIGNED</p> <p><b>SEPT. 16, 1972</b></p>                                                                                                                                                                                                                                                                                            |                                                                                 | <p>23C. PHYSICIAN'S NAME (Type)</p> <p><b>ANTONIO GATDULA M.D.</b></p> |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><b>Burial</b></p>                                                                                                                                                                                                                                                                                                          |                                    |                                                                                                                                                                        | <p>24B. DATE</p> <p><b>9/19/72</b></p>                                                                                                                                                                                                                                                                                                          |                                                                                 | <p>24C. NAME OF CEMETERY or CREMATORY</p> <p><b>St. Peters</b></p>     |
| <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><b>SEP 20 1972</b></p>                                                                                                                                                                                                                                                                                                              |                                    |                                                                                                                                                                        | <p>25B. NAME OF REGISTRAR</p>                                                                                                                                                                                                                                                                                                                   |                                                                                 | <p>25C. FUNERAL DIRECTOR ADDRESS</p> <p><b>Westernport, Md.</b></p>    |

2008143



## 72 08986 CERTIFICATE OF DEATH

STATE OF MARYLAND-DEPT

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

2. DATE AND HOUR OF DEATH

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5. SEX

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Yr.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 4/10/91

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner ☒)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 8:40 am 9/13 19 72 to 6:15 am 9/14 19 72  
that (1) (we) last saw the deceased alive on 6:10 am 9/14 19 72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S  
NAME (Type)

P. Zopolsky

DEGREE

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

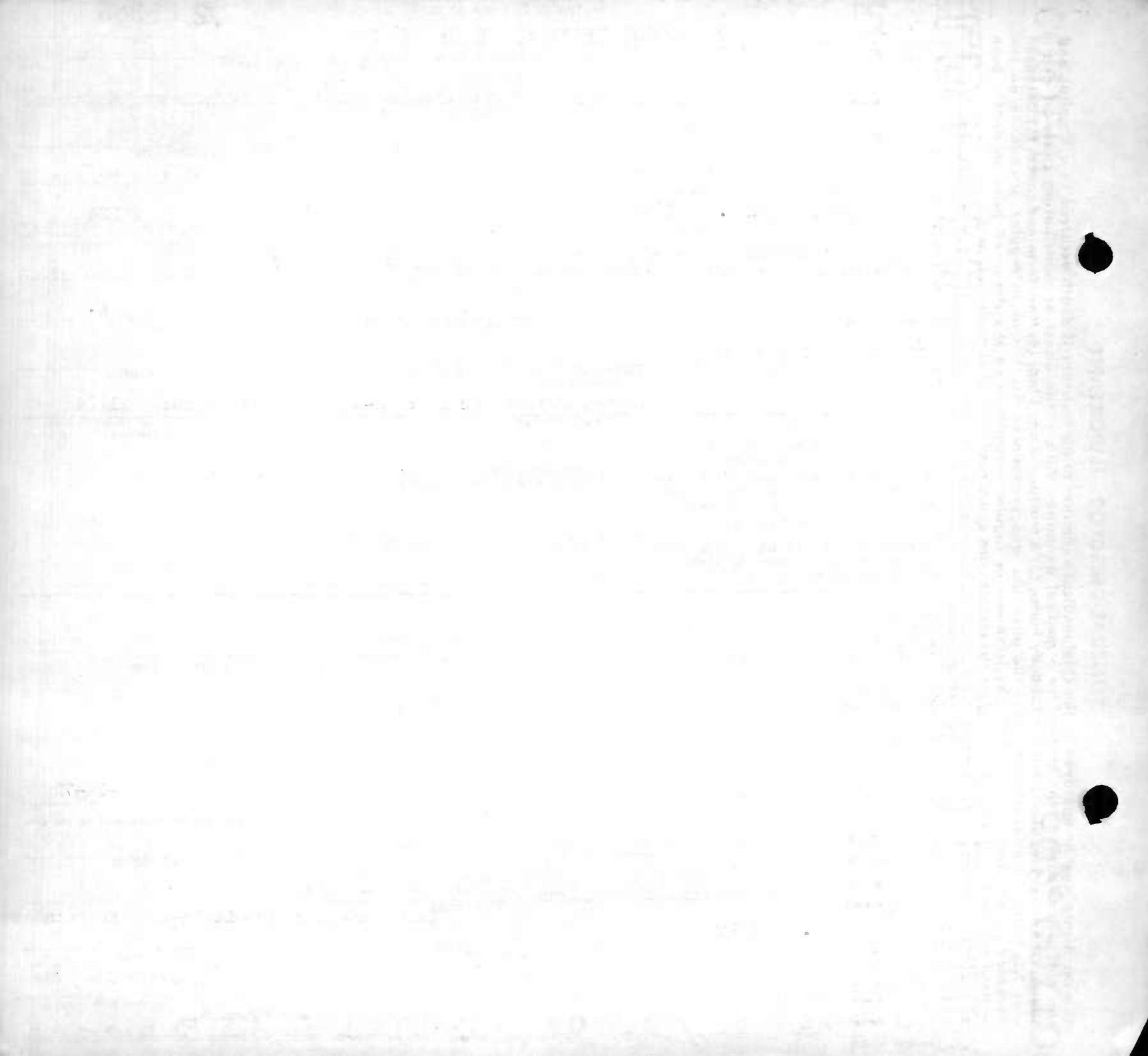
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

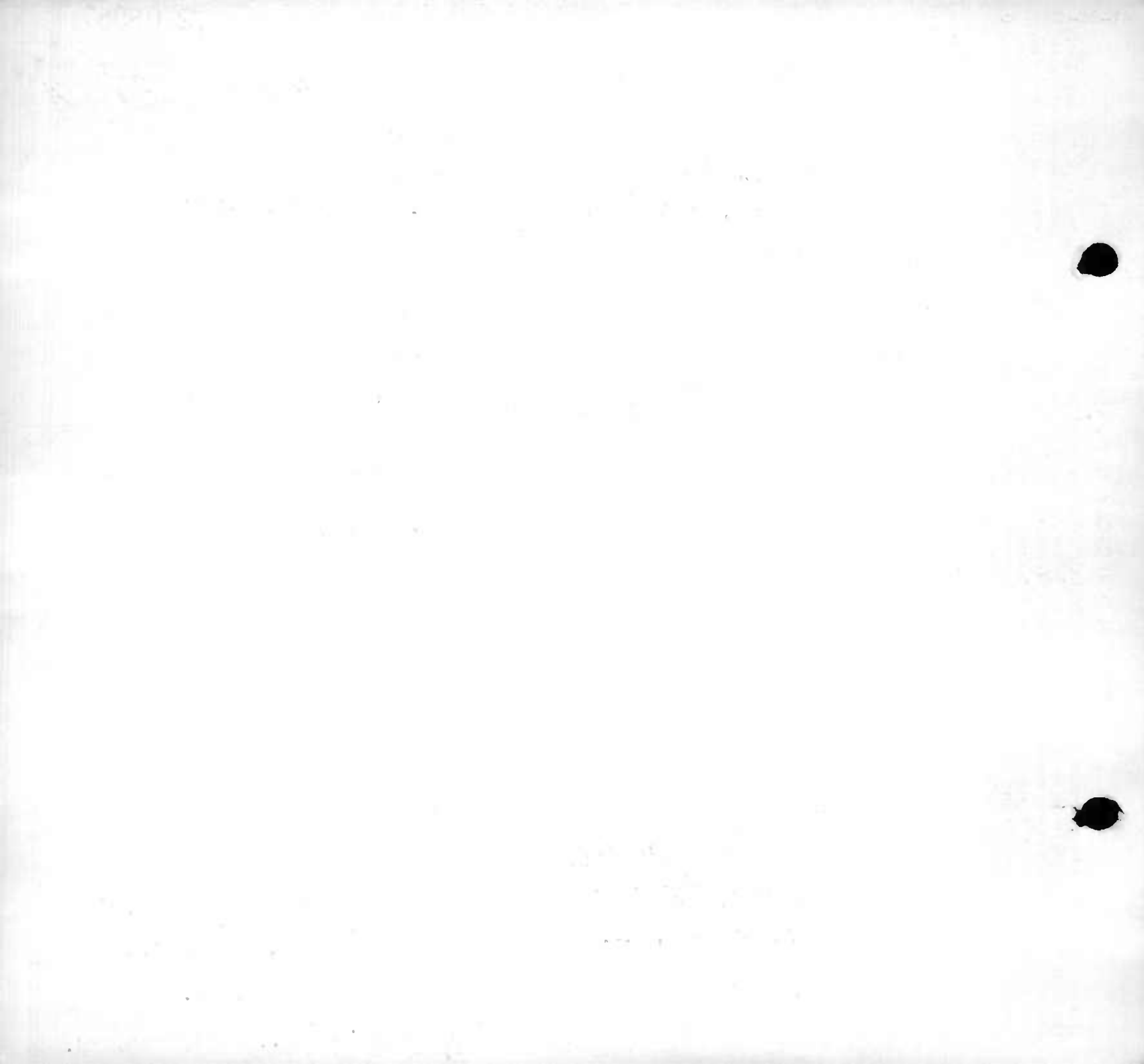
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.                                                                                                                                                                                                                                                                                                                                              |                      | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                        |                            | REG. NO.                                                                                      |                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------|
| P-156                                                                                                                                                                                                                                                                                                                                                  |                      | 72 08987                                                                                                                                                                                |                            | 72 08987                                                                                      |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                 |                      | 2. DATE AND HOUR OF DEATH                                                                                                                                                               |                            | STATE OF MARYLAND-DEHE                                                                        |                                                        |
| Steven Popomaronis                                                                                                                                                                                                                                                                                                                                     |                      | 9/16/72 5:35 A.M.                                                                                                                                                                       |                            |                                                                                               |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                   |                            |                                                                                               |                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31                                                                                                                                                                                                                                                                                                             |                      | A. STATE<br>Maryland                                                                                                                                                                    |                            | B. COUNTY<br>2605                                                                             |                                                        |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                                                                                                                                   |                      | C. CITY OR TOWN<br>Baltimore                                                                                                                                                            |                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                        |
| E. STREET AND NUMBER<br>617 S. Ponca Street 21224                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                                                         |                            |                                                                                               |                                                        |
| 5. SEX<br>Male                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br>Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                             | 8. DATE OF BIRTH<br>5/2/54 | 9. AGE On years (last birthday)<br>18                                                         | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Student                                                                                                                                                                                                                                                 |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br>-                                                                                                                                                  |                            | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                         |                                                        |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                    |                      | 13. FATHER'S NAME<br>Thomas                                                                                                                                                             |                            | 14. MOTHER'S MAIDEN NAME<br>Helen Vasilakis                                                   |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                         |                      | 16. SOCIAL SECURITY NO.<br>216-46-5880                                                                                                                                                  |                            | 17. INFORMANT ADDRESS<br>BCH RECORDS: 4940 Eastern Avenue                                     |                                                        |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      | (A) IMMEDIATE CAUSE<br>Respiratory failure<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Pneumococcal sepsis and<br>secondary influenza pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 hrs<br>3 days                               |                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |                      |                                                                                                                                                                                         |                            |                                                                                               |                                                        |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                        |                            | 20A. AUTOPSY? (Yes or No)                                                                     |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                        |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                              |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                               |                            | 21F. HOW DID INJURY OCCUR?                                                                    |                                                        |
| 22. I certify that (X) (this hospital) attended the deceased from 9/14 1972 to 9/16 1972 that (X) (we) last saw the deceased alive on 9/16 1972 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.                                                    |                      |                                                                                                                                                                                         |                            |                                                                                               |                                                        |
| 23A. SIGNATURE<br>Michael Pozen, M.D.                                                                                                                                                                                                                                                                                                                  |                      | 23B. DATE SIGNED<br>9/16/72                                                                                                                                                             |                            | 23C. PHYSICIAN'S NAME (Type)<br>Michael Pozen, M.D.                                           |                                                        |
| 23D. ADDRESS<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                                                                                                                                                                                                                       |                      | 23E. NAME OF REGISTRAR<br>Nicholas T. Matthews                                                                                                                                          |                            | 23F. FUNERAL DIRECTOR ADDRESS<br>3021 Eastern Ave., Baltimore, Md.                            |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                     |                      | 24B. DATE<br>9/19/72                                                                                                                                                                    |                            | 24C. NAME OF CEMETERY or CREMATORY<br>Greek Orthodox Cemetery                                 |                                                        |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.                                                                                                                                                                                                                                                                                        |                      | 24E. DATE REC'D BY HEALTH DEPT.<br>SEP 20 1972                                                                                                                                          |                            | 24F. NAME OF REGISTRAR<br>Nicholas T. Matthews                                                |                                                        |



72 08988

STATE OF MARYLAND - DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08988

BIRTH NO.

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                                                                           |                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Donald I. Queen</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>9 17 72 4:40A. M.</b>                                                       |                                                                      |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>2731 Parkwood Avenue</b>                                                                                                                                                                                                                                                                                                                      |                             | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>9 17 72 4:40 A. M.</b>                                                                                                                               |                                                                      |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1304</b>                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                                                                           |                                                                      |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7. RACE<br><b>Negro</b>     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                               |                                                                      |
| 9. DATE OF BIRTH<br><b>6-15-29</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             | 10. AGE (In years last birthday)<br><b>43</b>                                                                                                                                                             |                                                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                             |                                                                      |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Maintenance</b>                                                                                                                                                                                                                                                                                                                                                                                                           |                             | 15. MOTHER'S MAIDEN NAME<br><b>Dorothy Talbert</b>                                                                                                                                                        |                                                                      |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes 4-5-51*12-17-53</b>                                                                                                                                                                                                                                                                                                                                                                                      |                             | 17. SOCIAL SECURITY NO.<br><b>217246869</b>                                                                                                                                                               |                                                                      |
| 18. INFORMANT <b>Lynn Wilson -</b> ADDRESS<br><b>Dorothy Queen 618 Edgewood St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                                                                                                                                                                                           |                                                                      |
| 19. CAUSE OF DEATH<br><b>E 966X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                              |                                                                      |
| 20A. DATE OF OPERATION<br><b>7</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                             | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                          |                                                                      |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                            |                             | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>house</b>                                                                                                  |                                                                      |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>9 17 72 3:30A. M.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                         |                                                                      |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?<br><b>1st fl. 2731 Parkwood Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                             | 22F. HOW DID INJURY OCCUR?<br><b>stabbed during altercation</b>                                                                                                                                           |                                                                      |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                              |                             |                                                                                                                                                                                                           |                                                                      |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>William P. Mulloy, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>9-17-72</b> |                                                                      |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24B. DATE<br><b>9-22-72</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Auburn Cem.</b>                                                                                                                                              | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             | 25B. NAME OF REGISTRAR<br><b>Sidney Johnston</b>                                                                                                                                                          | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Kelson F.H. 1348 Calhoun St.</b> |

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  |  |                                                                                                        |  |                                                                                       |  |                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| U-362                                                                                                                                                                                                                                                                                                                         |                         | 72 08989                                                                                                                                         |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                       |  | X                                                                                     |  | REG. NO. 72 08989                                                                             |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                     |                         | 1. NAME OF DECEASED<br>(Type or Print) <u>Waters, Gwendolyn FAYE</u>                                                                             |  |                                                                                                        |  | 2. DATE AND HOUR OF DEATH<br><u>9-16-72</u> <u>11:10</u> <u>Am.</u>                   |  |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                  |  |                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Univ. of Md. Hospital - STU.</u>                                                                                                                                                                                                                                                   |                         |                                                                                                                                                  |  |                                                                                                        |  | A. STATE<br><u>MD.</u>                                                                |  | B. COUNTY<br><u>WORCESTER</u>                                                                 |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                          |                         |                                                                                                                                                  |  |                                                                                                        |  | C. CITY OR TOWN<br><u>Snow Hill, Md.</u>                                              |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| E. STREET AND NUMBER<br><u>Rt. 1 Box 77K</u>                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                  |  |                                                                                                        |  |                                                                                       |  |                                                                                               |  |
| 5. SEX<br><u>F</u>                                                                                                                                                                                                                                                                                                            | 6. RACE<br><u>Black</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>4-1-50</u>                                                                      |  | 9. AGE (in years last birthday)<br><u>22</u>                                          |  | 10. Under 1 Yr. Months: Days: Hours: Min.                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Asst. Program Director 4H-Extension</u>                                                                                                                                                                                     |                         |                                                                                                                                                  |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                      |  | 11. BIRTHPLACE (State or foreign country)<br><u>Palm Beach Fla</u>                    |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                 |  |
| 13. FATHER'S NAME<br><u>Samuel H. Waters</u>                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                  |  | 14. MOTHER'S MAIDEN NAME<br><u>Ellen Finch</u>                                                         |  |                                                                                       |  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                      |                         |                                                                                                                                                  |  | 16. SOCIAL SECURITY NO.<br><u>214-52-0058</u>                                                          |  | 17. INFORMANT<br><u>SAMUEL H. WATERS (SAME AS ABOVE)</u>                              |  |                                                                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><u>Multiple Trauma</u>                                                                                              |                         |                                                                                                                                                  |  | CAUSE OF DEATH<br><u>Multiple Trauma</u>                                                               |  |                                                                                       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>hours</u>                                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                |                         |                                                                                                                                                  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Cranio-cerebral Trauma</u>                   |  |                                                                                       |  |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  |  | (B) <u>Intra-peritoneal bleeding from</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>bruised abdomen</u> |  |                                                                                       |  | <u>hours</u>                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  |  | (C) _____                                                                                              |  |                                                                                       |  |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Possible sickle cell disease</u>                                                                                                                                                 |                         |                                                                                                                                                  |  |                                                                                                        |  |                                                                                       |  |                                                                                               |  |
| 19A. DATE OF OPERATION<br><u>9-16-72</u>                                                                                                                                                                                                                                                                                      |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Intra-peritoneal Bleeding</u>                                                             |  | 20A. AUTOPSY? (Yes or No)                                                                              |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |                                                                                               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)<br><u>auto accident</u>                                             |  | 21C. WHERE DID INJURY OCCUR?<br><u>Around Cambridge</u>                                                |  | (If in Baltimore City, give exact location)                                           |  |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)<br><u>9-16-72</u>                                                                                                                                                                                                                                                                               |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                        |  | 21F. HOW DID INJURY OCCUR?                                                                             |  | <u>5900</u>                                                                           |  |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-16-1972</u> to <u>9-16-1972</u> that (I) (we) last saw the deceased alive on <u>9-16-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                  |  |                                                                                                        |  |                                                                                       |  |                                                                                               |  |
| 23A. SIGNATURE<br><u>Michael P. Buchness M.D.</u>                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                  |  |                                                                                                        |  |                                                                                       |  | 23B. DATE SIGNED<br><u>9-16-72</u>                                                            |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Michael P. Buchness M.D.</u>                                                                                                                                                                                                                                                               |                         |                                                                                                                                                  |  |                                                                                                        |  |                                                                                       |  | 23D. ADDRESS                                                                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                      |                         | 24B. DATE<br><u>9-20-72</u>                                                                                                                      |  | 24C. NAME of CEMETERY or CREMATORY<br><u>Mt. Zion Baptist</u>                                          |  | 24D. LOCATION (City, town, or county) (State)<br><u>Snow Hill Md.</u>                 |  |                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>SEP 20 1972</u>                                                                                                                                                                                                                                                                         |                         | 25B. NAME OF REGISTRAR<br><u>James H. Heston</u>                                                                                                 |  | 25C. FUNERAL DIRECTOR<br><u>Northy Mem. Chapel - Salisbury, Md.</u>                                    |  | ADDRESS                                                                               |  |                                                                                               |  |

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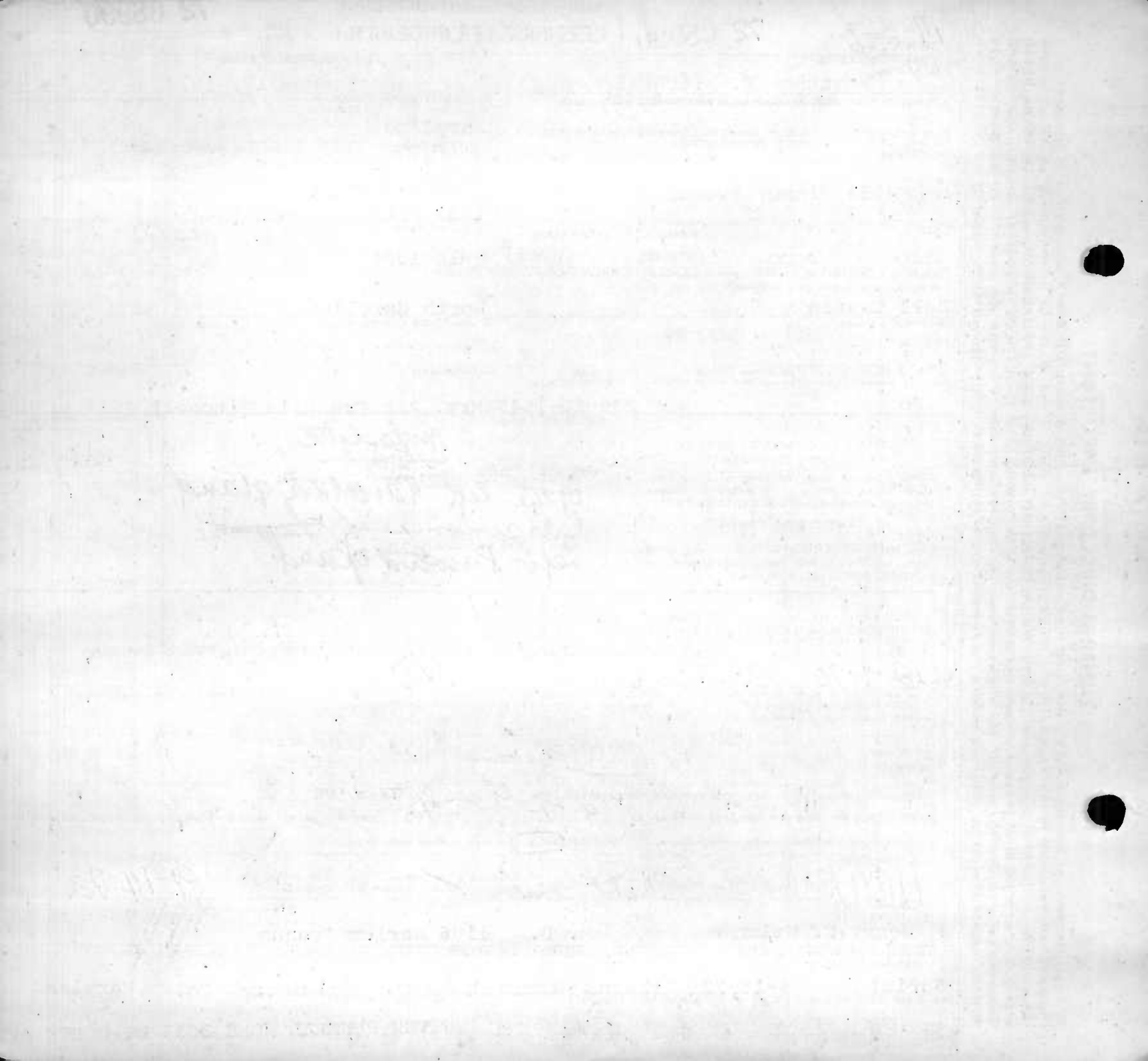
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                               | 72 08990                                                           | M-324                                              | 72 08990                                                             | CERTIFICATE OF DEATH         | REG. NO. 72 08990                          | STATE OF MARYLAND - DISTRICT      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------|------------------------------|--------------------------------------------|-----------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Matthew R. Mitchell</b>                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>September 12, 1972</b>                                                                                                                                                                                                                                                                                        |                                                                    |                                                    | M.                                                                   |                              |                                            |                                   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><b>4538 Finney Avenue</b>                                                                                                                                                  |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br><b>Maryland</b><br>B. COUNTY<br><b>2716</b><br>C. CITY OR TOWN<br><b>Baltimore</b><br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br><b>4538 Finney Avenue</b> |                                                                    |                                                    |                                                                      |                              |                                            |                                   |  |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-10-1906</b>                                                                                                                                                                                                                                                                                                          | 9. AGE (In years last birthday) <b>66</b>                          | If Under 1 Yr. Months: Days: Hours: Min.           |                                                                      | If Under 24 Hrs. Hours: Min. |                                            |                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bell Capain</b>                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                             |                                                                    |                                                    | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |                                   |  |
| 13. FATHER'S NAME<br><b>?</b>                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>?</b>                                                                                                                                                                                                                                                                                                          |                                                                    |                                                    |                                                                      |                              |                                            |                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>239-20-1645</b>                                                                                                                                                                                                                                                                                                 |                                                                    | 17. INFORMANT<br><b>Mrs. Ann Credella Mitchell</b> |                                                                      |                              |                                            | ADDRESS<br><b>4538 Finney Ave</b> |  |
| 18. <b>142.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Metastatic Carcinoma of the left Parotid gland</b><br>(B) <b>Carcinoma of the left Parotid gland</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Left Parotid gland</b>                                                                                       |                                                                    |                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 YRS.</b>        |                              |                                            |                                   |  |
| II                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                               |                                                                    |                                                    |                                                                      |                              |                                            |                                   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                               |                                                                    |                                                    |                                                                      |                              |                                            |                                   |  |
| 19A. DATE OF OPERATION<br><b>12-1-70</b>                                                                                                                                                                                                                                                                                                                  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer</b>                                                                                           |                                                                                                                                                                                                                                                                                                                                               | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                             |                                                    | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                              |                                            |                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                     |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                               | 21C. WHERE DID INJURY OCCUR?                                       |                                                    | (If in Baltimore City, give exact location)                          |                              |                                            |                                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                 |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                               | 21F. HOW DID INJURY OCCUR?                                         |                                                    |                                                                      |                              |                                            |                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-7-72</b> to <b>9-14-72</b> that (I) (we) lost saw the deceased alive on <b>9-7-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                     |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                               |                                                                    |                                                    |                                                                      |                              |                                            |                                   |  |
| 23A. SIGNATURE<br><b>Henry C. Welcome, M.D.</b>                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><b>9-14-72</b>                                                                                                                                                                                                                                                                                                            |                                                                    |                                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>Henry C. Welcome</b>              |                              |                                            |                                   |  |
| 23D. ADDRESS<br><b>M. D. 1106 Harlem Avenue</b>                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                               |                                                                    |                                                    |                                                                      |                              |                                            |                                   |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                  |                         | 24B. DATE<br><b>9-15-72</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                               | 24C. NAME OF CEMETERY or CREMATORY<br><b>Arbutus Memorial Park</b> |                                                    | 24D. LOCATION<br><b>Baltimore Co. Maryland</b>                       |                              | (City, town, or county) (State)            |                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                                     |                         | 25B. NAME OF REGISTRAR<br><b>...</b>                                                                                                                        |                                                                                                                                                                                                                                                                                                                                               | 25C. FUNERAL DIRECTOR<br><b>NUTTER FUNERAL HOME</b>                |                                                    | ADDRESS<br><b>3035 W. NORTH AV</b>                                   |                              |                                            |                                   |  |



| STATE OF MARYLAND - DEPT. OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| REG. NO. 72 08991                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| BIRTH NO. B-650                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) Patsy Brown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                         |  |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br>9 13 72 6:10 P. M. |                                                                  |  |                                                                                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>Sinai Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                         |  |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 13 72 6:10 P. M.                                                                          |                                                                  |  |                                                                                               |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1510                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| 6. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7. RACE<br>Negro                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                                                               | C. CITY OR TOWN<br>Baltimore                                     |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>3-7-1948                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10. AGE (In years last birthday)<br>24                  |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                       |                                                                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br>USA                              |  | 13. FATHER'S NAME<br>Charles Dennis                                                           |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>clerk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Social Security    |  | 15. MOTHER'S MAIDEN NAME<br>Pearl Thomas                                                                                                                    |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 17. SOCIAL SECURITY NO.                                 |  | 18. INFORMANT<br>Mrs. Pearl Dennis                                                                                                                          |                                                                                                                                               | ADDRESS<br>3937 Boarman Avenue                                   |  |                                                                                               |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>Sepsis and bronchopneumonia                                                                                                                                                                                     |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?<br>? ?                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR?<br>11 ? 69 ? m. shot in abdomen                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>Marvin S. Platt, M.D.</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9-14-72<br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |                                                         |  |                                                                                                                                                             |                                                                                                                                               |                                                                  |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br>9-18-1972                                  |  | 24C. NAME OF CEMETERY or CREMATORY<br>Maryland National Cem.                                                                                                |                                                                                                                                               | 24D. LOCATION (City, town, or county) (State)<br>Laurel Maryland |  |                                                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 20 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR<br><i>Richard J. [illegible]</i> |  | 25C. FUNERAL DIRECTOR<br>NUTTER FUNERAL HOME                                                                                                                |                                                                                                                                               | ADDRESS<br>3035 W. NORTH AV                                      |  |                                                                                               |  |

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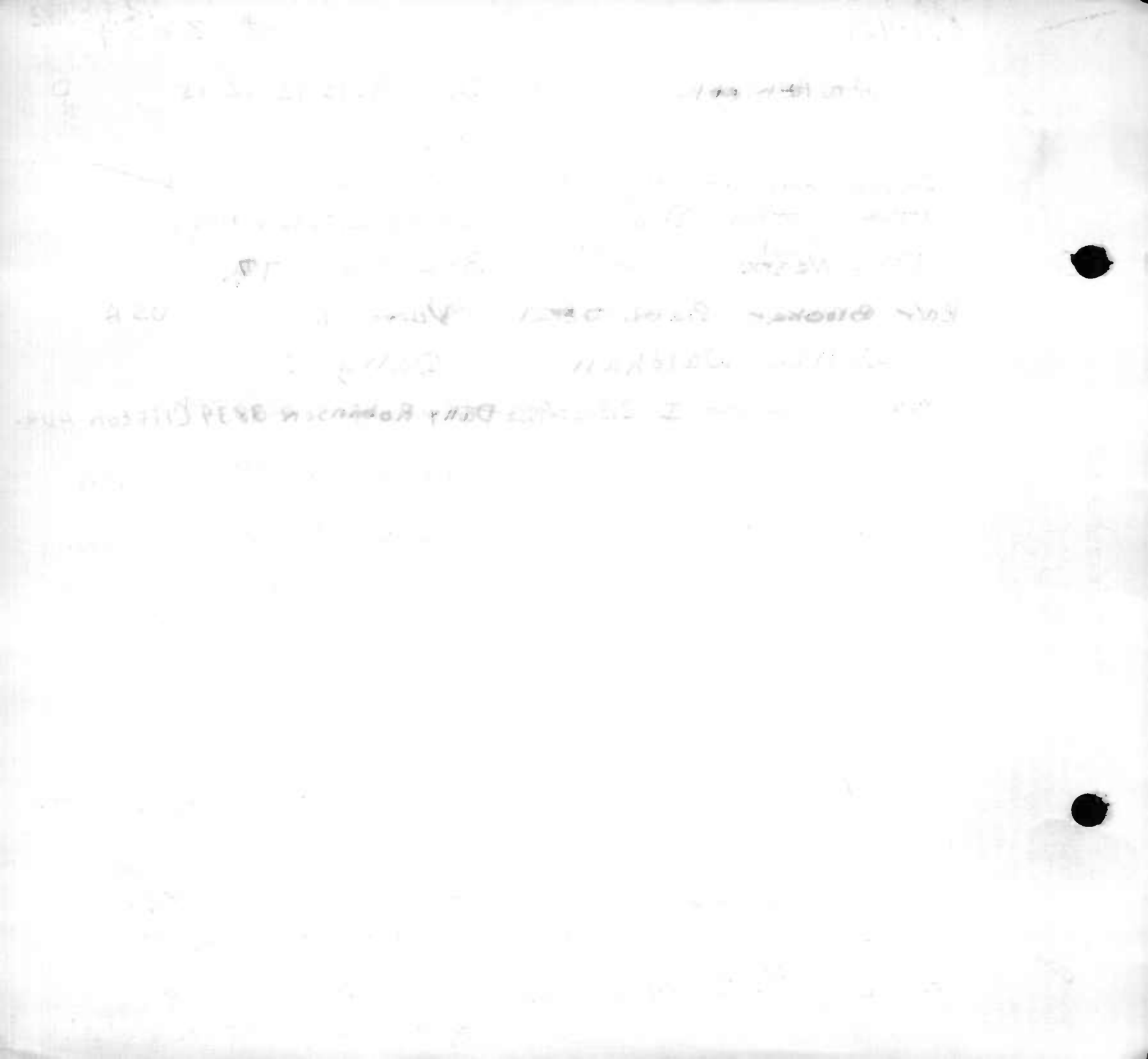
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |  | REG. NO. <b>2659</b>                                                                                                                                                                                                                                                   |  |
| W-434 72 08992                                                                                                                                                                                                                                                                                                                                         |  | 72 08992                                                                                                                                                                                                                                                               |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                              |  | STATE OF MARYLAND - DEMO                                                                                                                                                                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Walthall - Andrew D.</b>                                                                                                                                                                                                                                                                                     |  | 2. DATE AND HOUR OF DEATH<br><b>9-12-72 12:15</b>                                                                                                                                                                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>1509</b>                                                                                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Bolton Hill Nursing Home</b><br><b>1400 John St.</b>                                                                                                                                                                                                                                                        |  | C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                               |  |
| 5. SEX <b>Male</b> 6. RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                       |  | 8. DATE OF BIRTH <b>8-2-95</b> 9. AGE (In years last birthday) <b>77</b>                                                                                                                                                                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Blocker</b>                                                                                                                                                                                                                                         |  | 11. BIRTHPLACE (State or foreign country) <b>Va.</b>                                                                                                                                                                                                                   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <b>Bath. Steel</b>                                                                                                                                                                                                                                                                                                   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                                                                                                |  |
| 13. FATHER'S NAME <b>Willie Walthall</b>                                                                                                                                                                                                                                                                                                               |  | 14. MOTHER'S MAIDEN NAME <b>Dally ?</b>                                                                                                                                                                                                                                |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>                                                                                                                                                                                                                        |  | 16. SOCIAL SECURITY NO. <b>213-07-9253</b>                                                                                                                                                                                                                             |  |
| 17. INFORMANT <b>Dally Robinson</b>                                                                                                                                                                                                                                                                                                                    |  | ADDRESS <b>3839 Clifton Ave.</b>                                                                                                                                                                                                                                       |  |
| 18. <b>185 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CAUSATION lost. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Carcinoma prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF: <b>1971</b><br>(B) <b>arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF: <b>years</b><br>(C) <b>arteriosclerosis generalized</b><br><b>years</b> |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                        |  |
| 19A. DATE OF OPERATION <b>9/12/72</b>                                                                                                                                                                                                                                                                                                                  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                       |  |
| 20A. AUTOPSY? (Yes or No) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                               |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                               |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                        |  |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>                                                                                                                                                                                            |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                             |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> 19 <b>72</b> to <b>9/12</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |                                                                                                                                                                                                                                                                        |  |
| 23A. SIGNATURE <b>[Signature]</b>                                                                                                                                                                                                                                                                                                                      |  | 23B. DATE SIGNED <b>9/13/72</b>                                                                                                                                                                                                                                        |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Dr. H. M. H. H. H.</b>                                                                                                                                                                                                                                                                                                 |  | 23D. ADDRESS <b>2 E. Rod St. Balto. Md 21202</b>                                                                                                                                                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                 |  | 24B. DATE <b>9/16/72</b>                                                                                                                                                                                                                                               |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>                                                                                                                                                                                                                                                                                                   |  | 24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD</b>                                                                                                                                                                                                     |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>                                                                                                                                                                                                                        |  |
| 25C. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>                                                                                                                                                                                                                                                                                                         |  | ADDRESS <b>3035 W. NORTH</b>                                                                                                                                                                                                                                           |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                         |  | REG. NO. <b>72 08993</b>                                                                                                                                                                                 |  |
| <b>C-636</b>                                                                                                                                                                                                                                                                                                                             |  | <b>72 08993</b>                                                                                                                                                                                          |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                   |  | 2. DATE AND HOUR OF DEATH                                                                                                                                                                                |  |
| <b>Delores I. Carter</b>                                                                                                                                                                                                                                                                                                                 |  | <b>9-19-72</b>                                                                                                                                                                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br><b>2233 Orleans Street</b>                                                                                                                                                                                                                                                                   |  | A. STATE<br><b>Maryland</b>                                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                          |  | B. COUNTY<br><b>603</b>                                                                                                                                                                                  |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                  |  | 6. RACE<br><b>Negro</b>                                                                                                                                                                                  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                 |  | 8. DATE OF BIRTH<br><b>4-20-27</b>                                                                                                                                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                              |  | 9. AGE (In years last birthday)<br><b>45</b>                                                                                                                                                             |  |
| 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                        |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                             |  |
| 13. FATHER'S NAME<br><b>Paul F. Carter</b>                                                                                                                                                                                                                                                                                               |  | 14. MOTHER'S MAIDEN NAME<br><b>Isabelle Glenn</b>                                                                                                                                                        |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                 |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                  |  |
| 17. INFORMANT<br><b>Mrs. Isabelle Carter 2233 Orleans St.</b>                                                                                                                                                                                                                                                                            |  | ADDRESS                                                                                                                                                                                                  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Presumably gradual infection</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>atherosclerosis</b><br>(C) <b>hypertension</b> |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                             |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                         |  |
| 20A. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                 |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                 |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9-13-72</b> to <b>9-22-72</b> and that (I) (we) last saw the deceased alive on <b>9-13-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.              |  |                                                                                                                                                                                                          |  |
| 23A. SIGNATURE<br><b>W. W. Davis Jr.</b>                                                                                                                                                                                                                                                                                                 |  | 23B. DATE SIGNED<br><b>9-20-72</b>                                                                                                                                                                       |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                             |  | 23D. ADDRESS                                                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                |  | 24B. DATE<br><b>9-22-72</b>                                                                                                                                                                              |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>                                                                                                                                                                                                                                                                         |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>                                                                                                                                      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR<br><b>Wm C. March</b>                                                                                                                                                             |  |
| 25C. FUNERAL DIRECTOR<br><b>Wm C. March</b>                                                                                                                                                                                                                                                                                              |  | ADDRESS<br><b>928 E North Ave.</b>                                                                                                                                                                       |  |





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J-525 72 08994 STATE OF MARYLAND - DEATH BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 08994

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>GRACE L. JOHNSON</b>                                                                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.                                                                                           |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Memorial Hospital</b>                                                                                                                                                                                                                                                                              |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>9 18 1972 10:30 P.M.</b>                                                                                                                             |  |
| 6. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. RACE<br><b>white</b>                                                                                                                                                                                   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br><b>Balto.</b>                                                                                                                                                                          |  |
| 9. DATE OF BIRTH<br><b>7-1-1901</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 10. AGE (In years lost birthday)<br><b>71</b>                                                                                                                                                             |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                                                                                                               |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                                                                                                                                      |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                          |  | 17. SOCIAL SECURITY NO.<br><b>262-82-2934</b>                                                                                                                                                             |  |
| 18. INFORMANT<br><b>Mrs. Wilson Grubb</b>                                                                                                                                                                                                                                                                                                                                                                     |  | ADDRESS<br><b>Same</b>                                                                                                                                                                                    |  |
| 19. CAUSE OF DEATH<br><b>E812.11</b>                                                                                                                                                                                                                                                                                                                                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                              |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE<br><b>Massive pulmonary embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (B) <b>phlebothrombosis of left leg complicating multiple fractures of left ribs, left hemothorax and myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                        |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                           |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                          |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>street</b>                                                                                                 |  |
| 22D. TIME OF INJURY (APPROX.)<br><b>9-18-72 4 p.m.</b>                                                                                                                                                                                                                                                                                                                                                        |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                         |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>39th &amp; St. Paul Sts.</b>                                                                                                                                                                                                                                                                                                   |  | 22F. HOW DID INJURY OCCUR?<br><b>Passenger in auto-auto collision.</b>                                                                                                                                    |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                                                           |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type)<br><b>Russell S. Fisher, M.D.</b>                                                                                                                                                                                                                                                                                                                                     |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>9-20-72</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                     |  | 24B. DATE<br><b>9-21-72</b>                                                                                                                                                                               |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Druid Ridge</b>                                                                                                                                                                                                                                                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Md.</b>                                                                                                                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>H. W. Jenkins &amp; Sons Co.</b>                                                                                                                                             |  |
| 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS<br><b>4905 York Road Balto. Md. 21212</b>                                                                                                                                                         |  |

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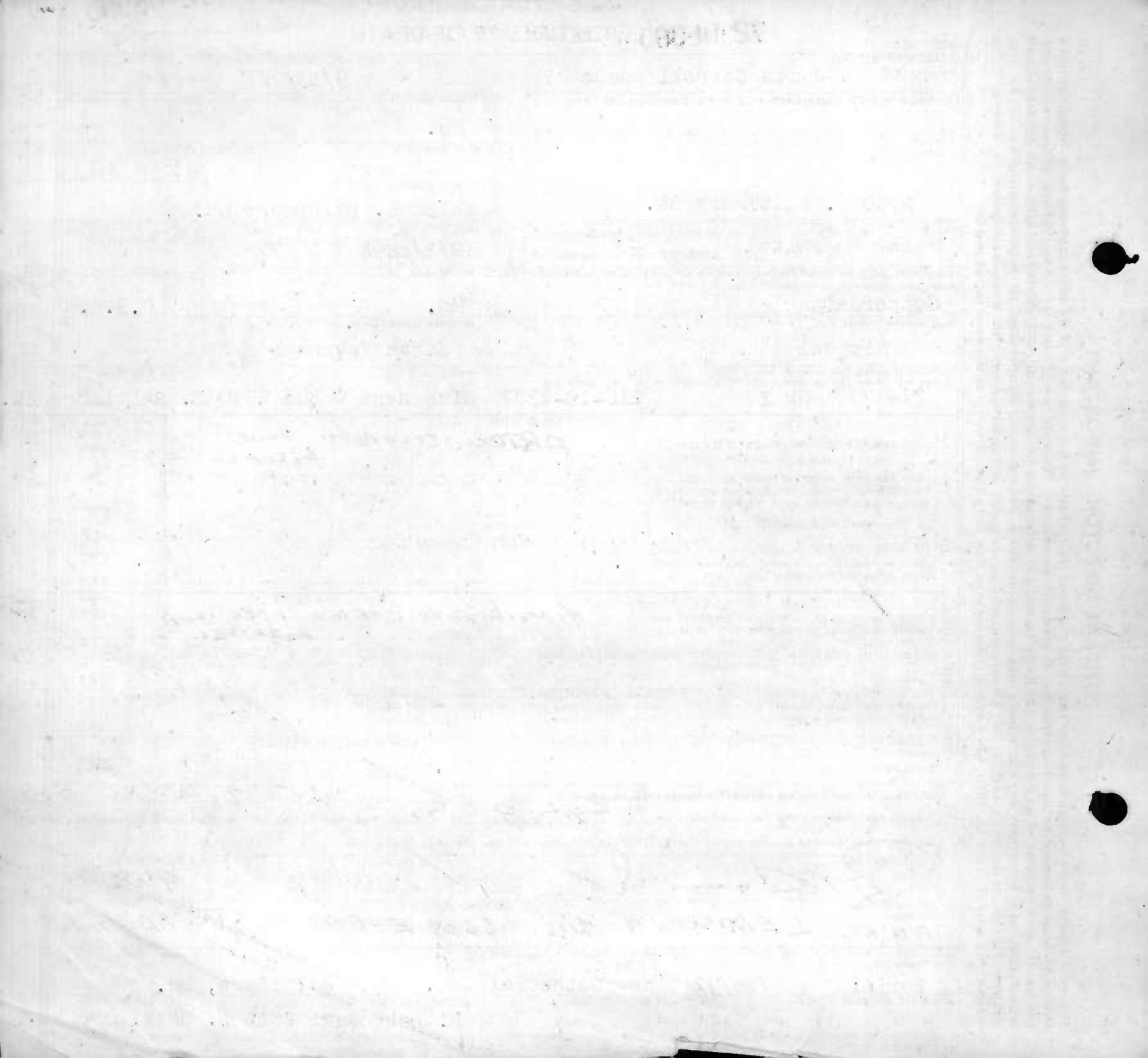
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

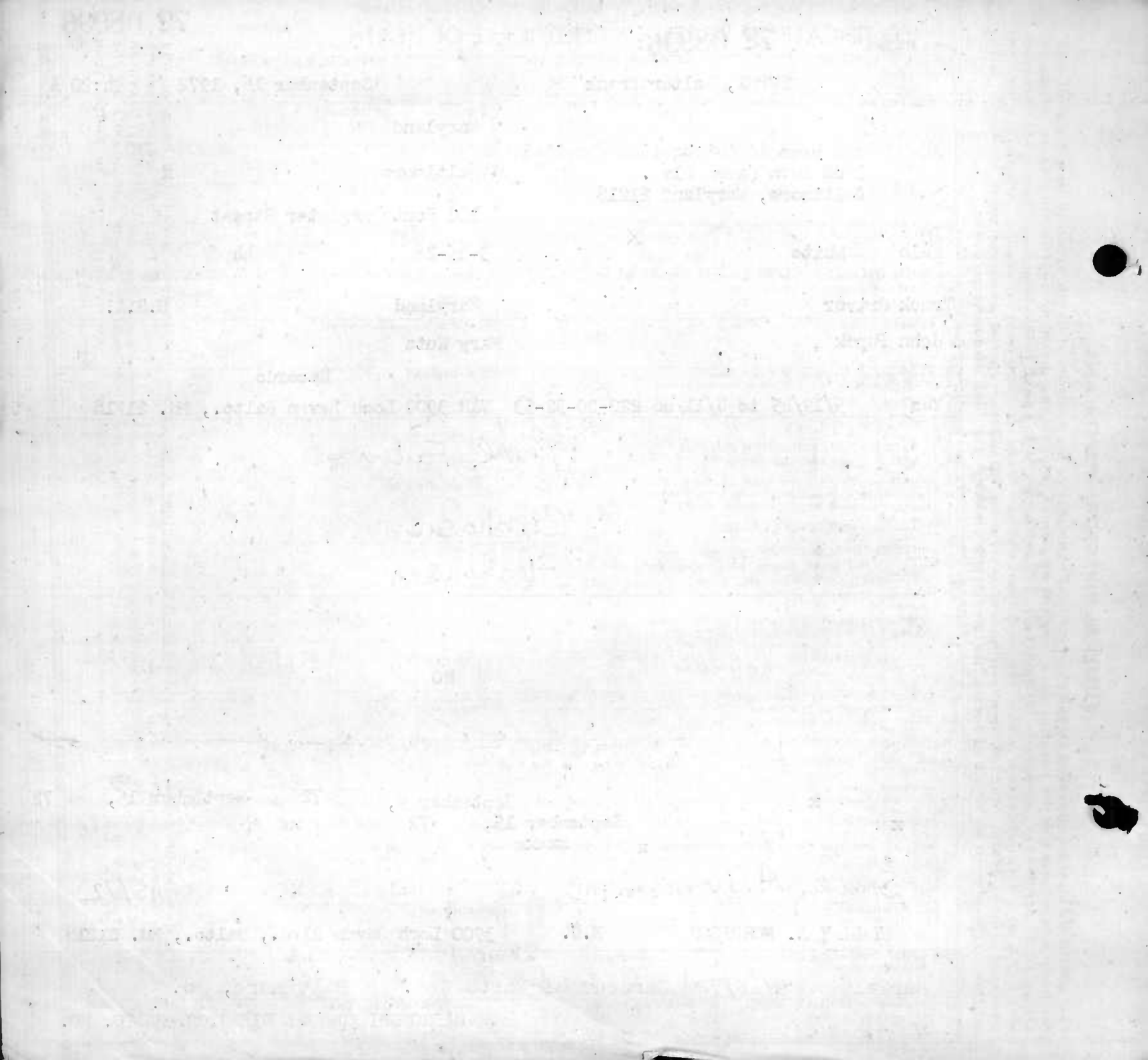
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| <div style="display: flex; justify-content: space-between;"> <span>W-320</span> <span>72 08995</span> <span>CERTIFICATE OF DEATH</span> </div>                                                                                                                                                                                                                                             |                                                                                                                                             | BALTIMORE CITY HEALTH DEPARTMENT<br>REG. NO. 72 08995                                                                                                                                                                                                                                                                 |  |
| BIRTH NO. _____<br>1. NAME OF DECEASED<br>(Type or Print) <b>James Carroll Woods</b>                                                                                                                                                                                                                                                                                                       |                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>9/13/72</b>                                                                                                                                                                                                                                                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>2730 E. Baltimore St.</b>                                                                                                                                                                                    |                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>602</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2730 E. Baltimore St.</b> |  |
| 5. SEX <b>Male</b><br>6. RACE <b>White</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                  | 8. DATE OF BIRTH <b>12/3/1894</b><br>9. AGE (In years lost birthday) <b>77</b><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coppersmith</b><br>10B. KIND OF BUSINESS OR INDUSTRY _____                                                                                                                                                             |  |
| 11. BIRTHPLACE (State or foreign country) <b>Md.</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                             | 13. FATHER'S NAME <b>Michael</b><br>14. MOTHER'S MAIDEN NAME <b>Sarah Kavanagh</b>                                                                                                                                                                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW I</b>                                                                                                                                                                                                                                                                |                                                                                                                                             | 16. SOCIAL SECURITY NO. <b>216-10-2307</b><br>17. INFORMANT <b>Miss Rose Woods</b> ADDRESS <b>2730 E. Baltimore St.</b>                                                                                                                                                                                               |  |
| 18. <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>ARTERIO SCLEROTIC HEART DISEASE</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>ARTERIO SCLEROTIC HEART DISEASE</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                                                                                                                                         |  |
| 19. DATE OF OPERATION <b>9/12/72</b><br>20A. AUTOPSY? (Yes or No) <b>No</b><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                        |                                                                                                                                             | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b>                                                                                                                                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/><br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____<br>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                     |                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____<br>21F. HOW DID INJURY OCCUR? _____                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>9/13</b> <b>1972</b> , that (I) (we) last saw the deceased alive on <b>Sept. 9</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                |                                                                                                                                             |                                                                                                                                                                                                                                                                                                                       |  |
| 23A. SIGNATURE <b>Andrew Lemischka</b><br>23C. PHYSICIAN'S NAME (Type) <b>ANDREW LEMISCHKA MD</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                             | 23B. DATE SIGNED <b>9/15-72</b><br>23D. ADDRESS <b>2608 E. BALTO ST. BALTO. MD.</b>                                                                                                                                                                                                                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b><br>24B. DATE <b>9/16/72</b><br>24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b><br>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>                                                                                                                                                                  |                                                                                                                                             | 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1972</b><br>25B. NAME OF REGISTRAR <b>Andrew Lemischka</b><br>25C. FUNERAL DIRECTOR <b>B. Dabrowski</b> ADDRESS <b>2818 E. Baltimore St.</b>                                                                                                                                |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                    | REG. NO. <b>72 08996</b>                                                                      |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 72 08996                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | CERTIFICATE OF DEATH                                                                                                                                        |                                    |                                                                                               |                                                           |
| BIRTH NO. <b>7-120</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>PUPEK, Walter Frank</b>                                                                                           |                                    | 2. DATE AND HOUR OF DEATH<br><b>September 15, 1972 4:20 A M.</b>                              |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>202</b>                      |                                    |                                                                                               |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Veterans Administration Hospital<br/>3900 Loch Raven Blvd.<br/>Baltimore, Maryland 21218</b>                                                                                                                                                                                                                                                                                  |                         | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                         |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
| E. STREET AND NUMBER<br><b>102 South Register Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-25-28</b> | 9. AGE (In years last birthday)<br><b>44</b>                                                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck driver</b>                                                                                                                                                                                                                                                                                                                                                                            |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 13. FATHER'S NAME<br><b>John Pupek</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 14. MOTHER'S MAIDEN NAME<br><b>Mary Kuta</b>                                                                                                                |                                    |                                                                                               |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 5/19/45 to 8/11/46</b>                                                                                                                                                                                                                                                                                                                                                     |                         | 16. SOCIAL SECURITY NO.<br><b>220-20-32-53</b>                                                                                                              |                                    | 17. INFORMANT<br><b>Records</b> ADDRESS<br><b>VAH 3900 Loch Raven Balto., Md. 21218</b>       |                                                           |
| 18. <b>57101</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease; injury or complication which caused death.)<br><b>Renal Failure</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Cirrhosis</b><br><b>Alcoholism</b>                                                                         |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                         |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 19A. DATE OF OPERATION<br><b>9/15/72</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                        |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                             |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 9, 1972</b> to <b>September 15, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 15, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <del>not</del> view the body after death. |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 23A. SIGNATURE<br><b>Stanley A. Morrison MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             |                                    | 23B. DATE SIGNED<br><b>9/15/72</b>                                                            |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>STANLEY A. MORRISON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 23D. ADDRESS<br><b>M.D. 3900 Loch Raven Blvd., Balto., Md. 21218</b>                                                                                        |                                    |                                                                                               |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 24B. DATE<br><b>9/18/72</b>                                                                                                                                 |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Gardens of Faith Cem.</b>                            |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                    |                                                                                               |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 25B. NAME OF REGISTRAR<br><b>Stanley A. Morrison</b>                                                                                                        |                                    | 25C. FUNERAL DIRECTOR<br><b>DABROWSKI FUNERAL DIRECTOR. BALTO. MD.</b>                        |                                                           |





72 08997

STATE OF MARYLAND - DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08997

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                       |                                                                                                                                                                          |                                        |                                                                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>John R. Owens</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |                                                       | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> 9 18 72<br>M.                                         |                                        |                                                                        |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                                       | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>9 18 72 7:24 a.<br>M.                                                                                                  |                                        |                                                                        |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE<br>Md.<br>B. COUNTY<br>Balto.                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                       | C. CITY OR TOWN<br>N. Linthicum<br>D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                         |                                        |                                                                        |  |
| 6. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 7. RACE<br>White | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                       | E. STREET AND NUMBER<br>724 Wedeman Avenue                                                                                                                               |                                        |                                                                        |  |
| 9. DATE OF BIRTH<br>Jan 3, 1954                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 10. AGE (In years last birthday)<br>18                                                                                                                      | 11. BIRTHPLACE (State or foreign country)<br>Maryland |                                                                                                                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |                                                                        |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Attendant                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                             |                                                       | 15. MOTHER'S MAIDEN NAME<br>Mary E. Ebberts                                                                                                                              |                                        |                                                                        |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes from June 1972                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                                       | 17. SOCIAL SECURITY NO.<br>220-60-9302                                                                                                                                   |                                        | 18. INFORMANT ADDRESS<br>Thomas Boone 724 Wedeman Ave. 21090           |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Gunshot wound of head<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                  |                                                                                                                                                             |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                             |                                        |                                                                        |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                                       | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                         |                                        |                                                                        |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                       | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>HOME                                                                         |                                        |                                                                        |  |
| 22C. WHERE DID INJURY OCCUR?<br>724 Wedeman Avenue (basement)                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |                                                       | 22F. HOW DID INJURY OCCUR?<br>Self inflicted.                                                                                                                            |                                        |                                                                        |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)<br>9 17 72 7:25p                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |                                                       | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                        |                                        |                                                                        |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                     |                  |                                                                                                                                                             |                                                       |                                                                                                                                                                          |                                        |                                                                        |  |
| ACTUAL EXAMINER'S NAME (Type)<br>Peter Lipkovic, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             |                                                       | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |                                        |                                                                        |  |
| DATE SIGNED<br>9/18/72                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             |                                                       |                                                                                                                                                                          |                                        |                                                                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 24B. DATE<br>9/21/72                                                                                                                                        |                                                       | 24C. NAME OF CEMETERY or CREMATORY<br>Lorraine Park Cemetery                                                                                                             |                                        | 24D. LOCATION (City, town, or county) (State)<br>Baltimore County, Md. |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>SEP 20 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 25B. NAME OF REGISTRAR<br>S. J. [Signature]                                                                                                                 |                                                       | 25C. FUNERAL DIRECTOR ADDRESS<br>Walters Funeral Home Pratt & Stricker<br>streets 21223                                                                                  |                                        |                                                                        |  |

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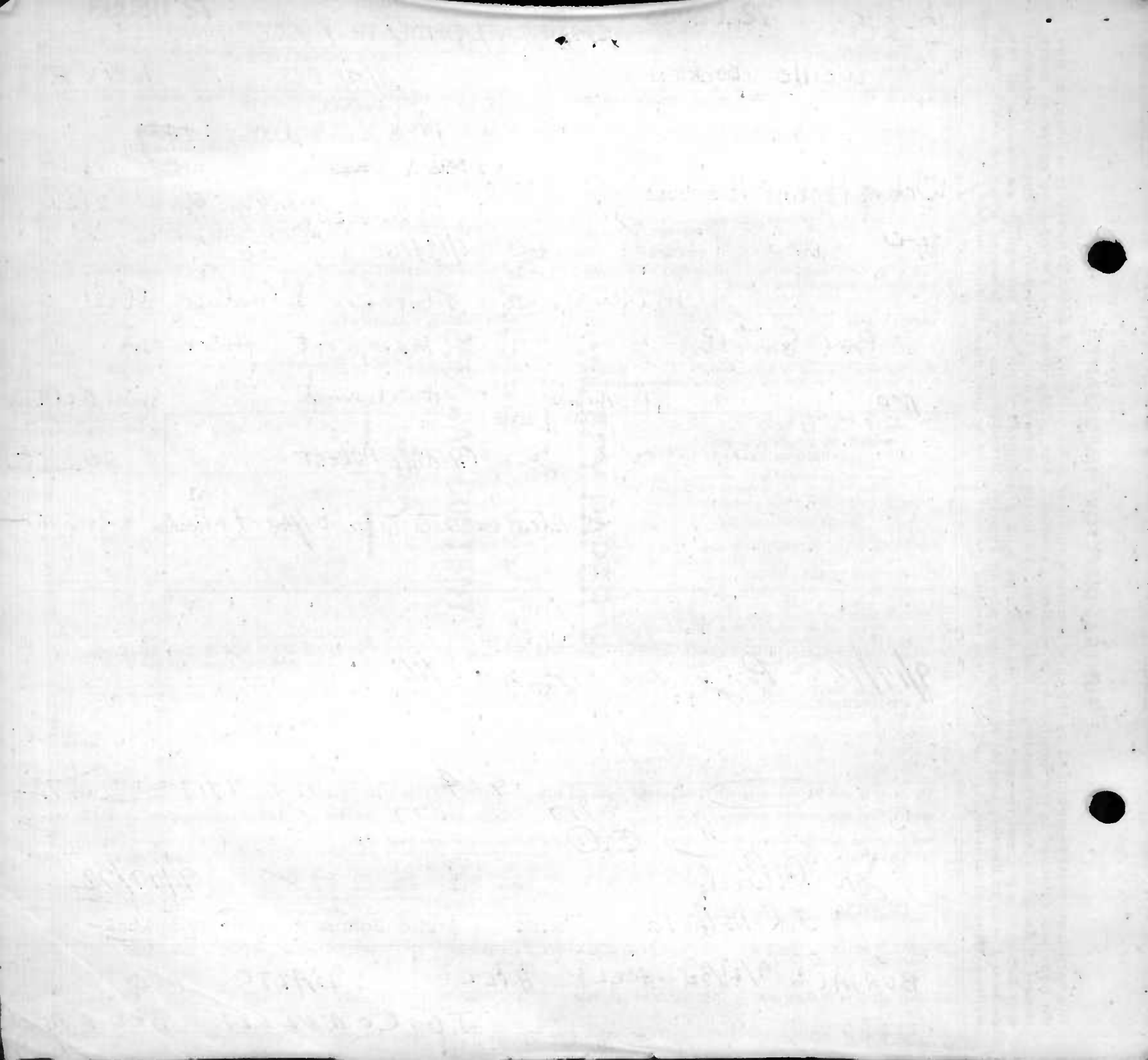
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

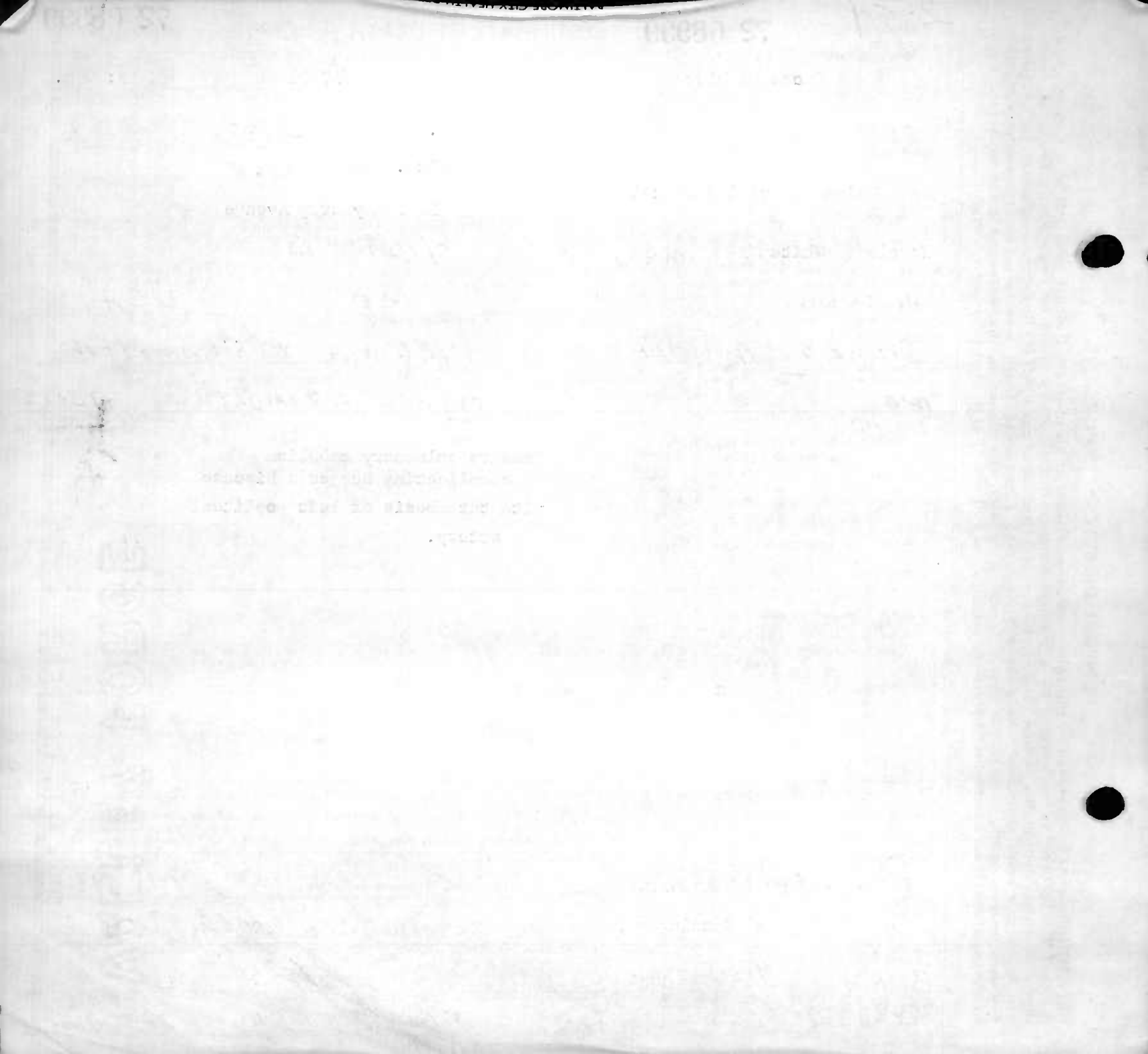
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                   | REG. NO. 72 08998                                                                    |                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------|
| B-245 72 08998                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                   | X CERTIFICATE OF DEATH                                                               |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Lucille Bucklen</b>                                                                                                                                                                                                                                                                                                                                                                 |                  | 2. DATE AND HOUR OF DEATH<br><b>9/18/72 1:15 A.M.</b>                                                                                                       |                                                                                                                                                                                                                                                                                                                                   | STATE OF MARYLAND-DMH                                                                |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Johns Hopkins Hospital</b>                                                                                                                                                                                                                      |                  |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTO CITY</b><br>C. CITY OR TOWN <b>ESSEX BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>414 S. Marlyn Ave 21221</b> |                                                                                      |                                                           |
| 5. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                               | 6. RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2/18/16</b>                                                                                                                                                                                                                                                                                                   | 9. AGE (In years last birthday) <b>56</b>                                            | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                   |                  | 10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>                                                                                                          |                                                                                                                                                                                                                                                                                                                                   | 11. BIRTHPLACE (State or foreign country) <b>Florence S. Carolina U.S.</b>           |                                                           |
| 13. FATHER'S NAME <b>Ben Smith</b>                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME <b>Margaret Harrison</b>                                                                                                                                                                                                                                                                                 |                                                                                      |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>                                                                                                                                                                                                                                                                                                            |                  | 16. SOCIAL SECURITY NO. <b>SINCE</b>                                                                                                                        |                                                                                                                                                                                                                                                                                                                                   | 17. INFORMANT <b>Husband</b> ADDRESS <b>Same as Above</b>                            |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiac ARREST</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, leading rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>Adenocarcinoma metastatic to Heart + Throat 2 months</b> |                  |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>                                                                                                                                                                                                                                                                    |                                                                                      |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                           |
| 19A. DATE OF OPERATION <b>9/17/72</b>                                                                                                                                                                                                                                                                                                                                                                                         |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERICARDIAL EFFUSION</b>                                                                                |                                                                                                                                                                                                                                                                                                                                   | 20A. AUTOPSY? (Yes or No) <b>NO</b>                                                  |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>None</b>                                                                                                                                                                                                                                                                                                                             |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>                                                        |                                                                                                                                                                                                                                                                                                                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b> |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>None</b>                                                                                                                                                                                                                                                                                                                                                         |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                   | 21F. HOW DID INJURY OCCUR? <b>None</b>                                               |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>9/11/72</b> to <b>9/17/72</b> that (I) (we) last saw the deceased alive on <b>9/17/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                       |                  |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                           |
| 23A. SIGNATURE <b>J.R. DePaulo</b>                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                             | 23B. DATE SIGNED <b>9/17/72</b>                                                                                                                                                                                                                                                                                                   |                                                                                      | 23C. PHYSICIAN'S NAME (Type) <b>J. R. DE PAULO</b> M.D.   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             | 24B. DATE <b>9/21/72</b>                                                                                                                                                                                                                                                                                                          |                                                                                      | 24C. NAME OF CEMETERY or CREMATORY <b>HOLLY HILL</b>      |
| 24D. LOCATION (City, town, or county) <b>BALTO. MD.</b>                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                             | 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                |                                                                                      |                                                           |
| 25B. NAME OF REGISTRAR <b>A. J. Connelly</b>                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             | 25C. FUNERAL DIRECTOR <b>J. G. CONNELLY</b> ADDRESS <b>300 MACE</b>                                                                                                                                                                                                                                                               |                                                                                      |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                             |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                 |  |                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| 72 08999                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                             |  |                                                                                                                  |  | Registered No.                                                                                                                                                                                                                                                                                        |  | 72 08999                                                                        |  |                                                                             |  |
| STATE OF MARYLAND - DEPT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                             |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                 |  |                                                                             |  |
| <b>BIRTH NO.</b> 2-514<br><b>M.E. CASE NO.</b> 72 08999<br><b>1. NAME OF DECEASED</b> (Type or Print) <i>Irene Zimbler</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                             |  |                                                                                                                  |  | <b>2. DATE AND HOUR OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <span>9/17/72</span> <span>9:00 p. M.</span> </div>                                                                                                                                                  |  |                                                                                 |  |                                                                             |  |
| <b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b><br><br><div style="display: flex;"> <div style="flex: 1;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br/> <div style="font-size: 2em; margin-left: -20px;">44</div>           Union Memorial Hospital         </div> <div style="flex: 1; font-size: 0.8em;">           (If not in hospital at institution, give street address or location)         </div> </div>                                                                                                                                                                                                                                                                           |  |                             |  |                                                                                                                  |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>A. STATE</b> Md.           </div> <div style="width: 55%;"> <b>B. COUNTY</b> BALTO.           </div> </div> |  |                                                                                 |  |                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                             |  |                                                                                                                  |  | <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township)<br>Balto. ROSEDALE                                                                                                                                                                                                     |  |                                                                                 |  |                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                             |  |                                                                                                                  |  | <b>D. STREET ADDRESS</b> (If rural, give location)<br>3805 Mayberry Avenue                                                                                                                                                                                                                            |  |                                                                                 |  |                                                                             |  |
| <b>5. SEX</b><br>female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>6. RACE</b><br>White     |  | <b>7. MARRIED, NEVER MARRIED</b><br>WIDOWED, DIVORCED (specify)<br>MARRIED                                       |  | <b>8. DATE OF BIRTH</b><br>6/7/27                                                                                                                                                                                                                                                                     |  | <b>9. AGE</b> (In years lost birthday)<br>45                                    |  | <b>If Under 1 Yr.</b><br>Months Days Hours Min.                             |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                             |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>                                                                         |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br>MD.                                                                                                                                                                                                                                               |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>USA                                      |  |                                                                             |  |
| <b>13. FATHER'S NAME</b><br>JAMES A. WILEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                             |  |                                                                                                                  |  | <b>14. MOTHER'S MAIDEN NAME</b><br>VIRGINIA R. CRAMPTON                                                                                                                                                                                                                                               |  |                                                                                 |  |                                                                             |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                             |  | <b>16. SOCIAL SECURITY NO.</b>                                                                                   |  | <b>17. INFORMANT</b> ADDRESS<br>MYRON L. ZIMBLER ABOVE                                                                                                                                                                                                                                                |  |                                                                                 |  |                                                                             |  |
| <b>18. CAUSE OF DEATH</b><br><div style="display: flex;"> <div style="flex: 1;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>           (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br/><br/> <b>ANTECEDENT CAUSES</b><br/>           DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div> <div style="flex: 1;"> <b>(A) DUE TO</b> Massive pulmonary embolism complicating Berger's Disease with thrombosis of left popliteal artery.<br/><br/> <b>(B) DUE TO</b><br/><br/> <b>(C)</b> </div> </div> |  |                             |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                 |  |                                                                             |  |
| <b>INTERVAL BETWEEN ONSET AND DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                             |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                 |  |                                                                             |  |
| <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                             |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                 |  |                                                                             |  |
| <b>19A. DATE OF OPERATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                             |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                          |  |                                                                                                                                                                                                                                                                                                       |  | <b>20A. AUTOPSY?</b> (Yes or No)                                                |  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                             |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |                                                                                                                                                                                                                                                                                                       |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) |  |                                                                             |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                             |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |                                                                                                                                                                                                                                                                                                       |  | <b>21F. HOW DID INJURY OCCUR?</b>                                               |  |                                                                             |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>                                                                                                                                                                                                                                                                                                                                                                |  |                             |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                 |  |                                                                             |  |
| <b>23A. SIGNATURE</b><br><i>Raymond M. Cunningham</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                             |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                       |  | <b>23B. DATE SIGNED</b><br>9-18-72                                              |  |                                                                             |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br>Raymond Cunningham, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                             |  |                                                                                                                  |  | <b>23D. ADDRESS</b><br>323 Medical Arts Bldg. Balto. 21201                                                                                                                                                                                                                                            |  |                                                                                 |  |                                                                             |  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | <b>24B. DATE</b><br>9/21/72 |  | <b>24C. NAME OF CEMETERY or CREMATORY</b><br>MORELANDS                                                           |  |                                                                                                                                                                                                                                                                                                       |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br>BALTO. MD               |  |                                                                             |  |
| <b>25A. DATE REC'D BY HEALTH DEPT</b><br>SEP 20 1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                             |  | <b>25B. NAME OF REGISTRAR</b><br><i>Lidney Johnston</i>                                                          |  |                                                                                                                                                                                                                                                                                                       |  | <b>25C. FUNERAL DIRECTOR</b> ADDRESS<br>J.G. CONNELLY 300 MACE                  |  |                                                                             |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                         | REG. NO. <b>72 09000</b>                                                 |                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------|
| C-640 72 09000                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                         | STATE OF MARYLAND-DEPT                                                   |                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                         | STATE OF MARYLAND-DEPT                                                   |                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Edward W. Charlton</b>                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>Sept 16/72 10A.</b>                                                                     |                                                                          |                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                                   |                                                                          |                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00 3901 Labyrinth Rd.</b>                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | A. STATE <b>Ind.</b> B. COUNTY <b>2720</b>                                                                              |                                                                          |                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                          |                                               |
| E. STREET AND NUMBER <b>3901 Labyrinth Rd.</b>                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                         |                                                                          |                                               |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov 6/1916</b>                                                                                   | 9. AGE (In years lost birthday)<br><b>55</b>                             | 10. If Under 1 Yr. Months: Days: Hours: Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>                                                                                                                                                                                                                           |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>                                                                                                            | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Ind.</b>                                                     |                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>William Charlton</b>                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>Sophie Coplan</b>                                                                        |                                                                          |                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                |                         | 16. SOCIAL SECURITY NO.<br><b>214-22-3121</b>                                                                                                               | 17. INFORMANT<br><b>William Charlton</b>                                                                                |                                                                          | ADDRESS<br><b>Home</b>                        |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Occlusion</b>                                                                                    |                         |                                                                                                                                                             | CAUSE OF DEATH<br><b>Coronary Occlusion</b>                                                                             |                                                                          |                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                       |                         |                                                                                                                                                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Immediate</b>                                              |                                                                          |                                               |
| (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                     |                                                                          |                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                               |                         |                                                                                                                                                             |                                                                                                                         |                                                                          |                                               |
| 19A. DATE OF OPERATION<br><b>0</b>                                                                                                                                                                                                                                                                                                   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                         | 20A. AUTOPSY? (Yes or No)                                                |                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                       |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                            |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                         | 21F. HOW DID INJURY OCCUR?                                               |                                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Feb 3 1970</b> to <b>Sept 16 1972</b> , that (I) (we) last saw the deceased alive on <b>Feb 3 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                                         |                                                                          |                                               |
| 23A. SIGNATURE<br><b>Irvin Sauber</b>                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                                                                                                         | 23B. DATE SIGNED<br><b>9-16-72</b>                                       |                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><b>IRVIN SAUBER</b>                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                         | 23D. ADDRESS<br><b>6905 Park Heights Ave</b>                             |                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                            |                         | 24B. DATE<br><b>9/16/72</b>                                                                                                                                 |                                                                                                                         | 24C. NAME OF CEMETERY or CREMATOR<br><b>Ansley Emanuel</b>               |                                               |
| 24D. LOCATION<br><b>Balto, Ind.</b>                                                                                                                                                                                                                                                                                                  |                         | 24E. LOCATION<br><b>Balto, Ind.</b>                                                                                                                         |                                                                                                                         | 24F. LOCATION<br><b>Balto, Ind.</b>                                      |                                               |
| 25A. DEPT. OF HEALTH DEPT.<br><b>SEP 20 1972</b>                                                                                                                                                                                                                                                                                     |                         | 25B. NAME OF REGISTRAR<br><b>Irvin Sauber</b>                                                                                                               |                                                                                                                         | 25C. FUNERAL DIRECTOR<br><b>6010 Rusty Rd</b>                            |                                               |

